


Challenges in 2010 and Beyond for Inpatient and Outpatient Rehabilitation Providers Post Health Care Reform

AMRPA 8th Annual Medical Rehabilitation Education Conference
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What We Will Discuss

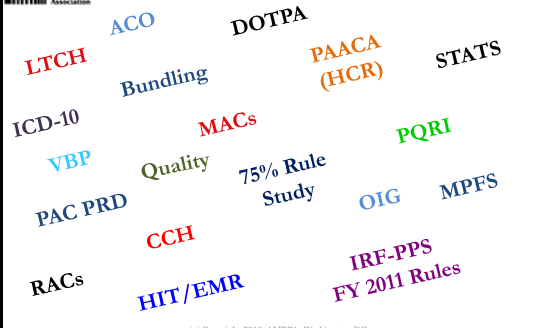
- Health Care Reform
- Regulatory Issues
 - Coverage Criteria
 - FY 2011 Updates
 - MACs, RACs, etc.
 - Outpatient Research
- 2011



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2010's Medical Rehabilitation Alphabet Soup



ACO DOTPA PAACA (HCR) STATS
LTCH Bundling
ICD-10 VBP Quality 75% Rule Study PQRI
PAC PRD CCH HIT/EMR IRF-PPS FY 2011 Rules
RACs OIG MPFS

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Medicare Participating Post-Acute Providers as of 2010

Type of Provider	1990	1996	2000	2004	2006 ⁵	2008	2010
Skilled Nursing Facilities	10,508	15,553	14,825	14,929	15,006 ⁷	15,041 ⁷	15,067
Home Health Agencies	5,793	9,886	7,528	7,341	8,587	9,382	10,945 ⁸
Rehabilitation Facilities (Hospitals and Units)	813	1,048	1,128	1,359 ³	1,229	1,195	1,189
Long-Term Care Hospitals	90	185	253 ⁴	317	393	393	428
CORFs	191	403	516 ²	638	627	517	401

1) As of February 2001, CMS
 2) As of April 1, 2002, CMS
 3) As of May, 2004, CMS
 5) As of August 2006, CMS
 7) MedPAC June 2009 Data Book
 8) As of May 2010, CMS

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State Of The Field

Inpatient Rehabilitation Facilities Statistics

	2001	2003	2005	2007	2009**	2010
Total IRFs*	1,157	1,211	1,231	1,202	1,194	1,189
Hospitals	214	215	217	219	224	227
Units	943	996	1,014	983	970	962
Total Beds*	35,115	36,785	37,294	36,187	38,483**	37,965**
Hospitals	12,760	13,513	13,137	12,917	14,281	14,484
Units	22,356	23,272	24,157	23,270	23,662	23,481


*MedPAC
 ^eRehabData@
 ~All numbers eRehabData@ (actual or interpolated)
 ** CMS OSCAR Reports to AMRPA

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To Be or Not to Be?


Answer: To Be!

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 **Two Aspects Of The Health Care Reform**
(P.L. 111-148 and P.L. 111-152)

1. Insurance Reform and Expanded Access
 - Inclusion of Rehabilitative Services in Benefit Package
 - Exchanges
 - Expansion of Coverage
2. Medicare and Medicaid Changes for All Providers
 - Provider Cuts for IRF, LTCHs, Others
 - Quality Indicators for Rehab, LTCH
3. Both Aspects Provide Opportunities for Rehabilitation Providers


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 **Conceptual Changes in the ACA**

\$ Cuts **Quality** **Reform-
Payment and
Delivery**

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 **Health Care Reform: Streaming Changes for Rehabilitation Hospitals/Units**

Phase I: Provider Payment Cuts

- FY 2010 – Start Update Cuts Through FY 2019
- FY 2012 – Productivity Adjustment Applied (Permanent)

Phase II Shift To Quality Platform: Move To Quality Reporting, Potential HAC and P4P Approach Plus Provider Cuts


- CY 2012 – 1/1/12: Report On Applying Hospital Acquired Conditions Policy to IRH/Us, LTCHs, Hospital OPD, SNFs, and ASCs.
- FY 2013 – IRH/U Quality Reporting Measures Published
- FY 2014 – IRH/U Quality Data Reporting Starts; 2% Reduction for Failure To Report
- CY 2016 – Pay For Performance Pilot Test Starts For IRH/Us, LTCHs, Psychiatric Hospitals and Units (P4P)
- CY 2018 – P4P May Be Expanded

Phase III: System Delivery Change And Finance Reform ^{(1) (2)}


- CY 2011 Etc: •ASPE / RTI Continue Bundling Research
- 6/2011 PAC PRD Report Due To Congress
- 1/1/12 Shared Savings/ACO Program
- By 1/1/2013 Start National Payment Program On Bundling and CCH Pilot Test Through 1/1/2018
- Other Demos and Pilots

¹⁾These Include Efforts Already Underway
²⁾There are Time Overlaps With Phases I And II


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 **Affordable Care Act of 2010**


- Updates
 - MB-0.25 FY 2010, Discharges Post 4/1/10
 - MB-0.25 FY 2011
 - MB-0.10 FY 2012-2013
 - MB-0.3 FY 14
 - MB-0.2 FY 15-16
 - MB-0.75 FY 17-19




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 **Affordable Care Act of 2010**


- Productivity Adjustment Starts FY 2012
- Adjustment Equals the 10 Year Moving Average of Changes in Annual Economy Wide Private Non Farm Business Multi-Factor Productivity (as Projected by the Secretary)
- May Result in Payment Rates Less Than Rates for Preceding FY



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 **Affordable Care Act of 2010**

- Quality Reporting for IRFs, LTCHs Starting FY 2014
- Quality Measures To Be Published by FY 2013 (10/1/2012) for FY 2014 (10/1/13)
- If An IRF/U Does Not Report Data, Payment Decreased by -2% After Reduction Taken for Productivity and The Market Basket Reductions.
- Result May Be Update Less Than Zero for Any FY
- AMRPA Quality Committee and Work Groups




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Question To The Audience




- **If You Could Choose, What 3-5 Quality Metrics Would You Suggest?**

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Payment Can Be Reduced

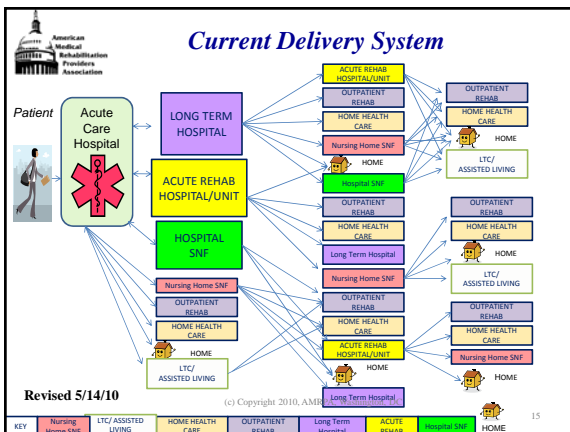


P = Standard Payment Rate -((MB-reduction)
(Productivity Adjustment Starting in FY 2012)-
(Quality Reporting Incentive -2% Starting in FY 2014))

Payment May be Further Reduced in the Future
by Application of the Hospital Acquired Condition
Policy and Value Based Purchasing Policies



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 **Affordable Care Act of 2010:
New Horizons**

- **Continuing Care Hospital Pilot**
 - Pilot Test Required as Part of Bundling Pilot;
 - May Also Be Done By Center for Medicare and Medicaid Innovation
 - Start by 1/1/13
 - 5 Years
- **Bundling Pilot**
 - Starting by 1/1/13
 - HHS Submits Plan to Congress 1/1/16 to Expand Program
 - Mentions the CARE Assessment Instrument
 - 5 Years




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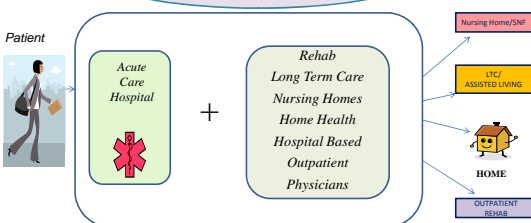
 **AMRPA Advocacy**

- **Continuing Care Hospital/Bundling**
- AMRPA CCH & Bundling Committee with Two Work Groups
 - Examining How to Implement CCH as Envisioned
 - Raise Issues Regarding Bundling Pilot To Assure Patients Continue to Receive Appropriate Rehab Services
 - Concerns Intended and Unintended Consequences

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 **Acute Bundle of Care**

For the Acute Care Admission and 30 Days Post Discharge




- ACH of ACO "Entity" Receives Payment
- Bundled, Bid, Other Payment
- Non-entities at risk
- Non entities negotiate for payments


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 **Acute and PAC Bundling**


- Numerous Issues:
 - Ethics
 - Access
 - Patient Choice
 - Bundle Holder
 - Definition of the Bundle
 - Episode of Care Defined
 - Payment Amount/Unit
 - Scope of Services




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 **Acute and PAC Bundling**


- Numerous Issues *cont'd*
 - Data/Assessment Instrument
 - Use of Quality Measures as Payment Incentives and Behavioral Governors
 - Risk Adjustment
 - Statutory and Regulatory Waivers
 - Cost Shifting




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 **Acute and PAC Bundling**

- Numerous Issues *cont'd*
 - Common HIT Platforms
 - Coordination of Benefits
 - Conditions
 - Post Acute Care Placement Criteria
 - Classification System for EOC (a.k.a. GROUPER)




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 **Glimpses of the Future for Bundling:
Acute Care Episodes Demonstration
(ACE)**

- CMS Acute and Physicians Bundling Project
- Sites in TX, OK
- Providers and Physicians Take 4-5% Discount Up Front
- CMS Weblink:
<https://www.cms.gov/demoprojectsevalrpts/md/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=3&sortOrder=descending&itemID=CMS1204388&intNumPerPage=10>


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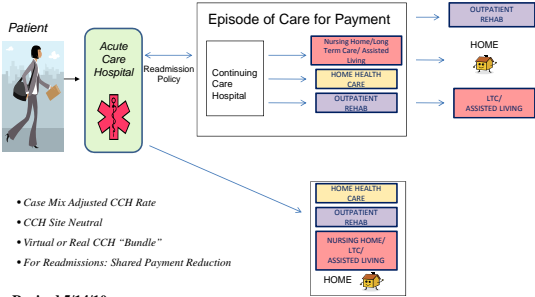
 **AMRPA Advocacy:
Continuing Care Hospital**

- Includes IRF, Hospital Based SNF, LTCH Levels of Care
- Hospital Stay Plus 30 Day Episode
- Virtual or Real
- Contract for Post CCH Hospital Services



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 **CCH Creates a Bundled PAC Episode
for Delivery System and Payment Reform**




Episode of Care for Payment


- Acute Care Hospital (Readmission Policy) → Continuing Care Hospital
- Continuing Care Hospital → Nursing Home/Long Term Care/Assisted Living
- Continuing Care Hospital → HOME HEALTH CARE
- Continuing Care Hospital → OUTPATIENT REHAB
- Continuing Care Hospital → LTC/ ASSISTED LIVING

- Case Mix Adjusted CCH Rate
- CCH Site Neutral
- Virtual or Real CCH "Bundle"
- For Readmissions: Shared Payment Reduction


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 **CCH Implementation Issues**


- Similar to Acute-PAC Bundling
- Common Management
- Patient Care and Safety Standards
- EOC
 - Time Frame
 - Services
 - Costs
 - Payment Amount (Method)
 - Classification



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 **CCH Implementation Issues**

- Bundle Holder
- Real or Virtual
- Assessment Tool
- Data on Patients, Provider Costs, Federal Payments
- Quality Metrics
- Regulatory and Statutory Waivers





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 **CCH Implementation Issues**

- Readmissions-Shared Pain
- Coordination of Benefits
- Special Payment Policies
- Some or All Conditions
- Evaluation Criteria



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 **Question To The Audience** 

How Many of You Would Like to Participate In The CCH Pilot?



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 **What Is CMS Doing on Bundling? Quality?** 

- See the Research
- See the Roadmaps
 - *CMS Roadmap for Quality Measurement in the Traditional Medicare Fee-for Service Program*
 - *CMS Roadmap for Resource Use Measurement in the Traditional Medicare Fee for Service Program*
 - *CMS Roadmap for Implementing Value Based Purchasing in the Traditional Medicare Fee for Service Program.*



 

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 **Post Acute Care Payment Reform Demonstration (PAC-PRD)** 


- Contact RTI at pat-comment@rti.org
- Project website – www.pacdemo.rti.org
- Expanded by 60 Facilities in 2010 to Chronically Critically Ill Patients
- Report Due June, 2011
- Hear the Principle Investigator Friday Morning


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 **RTI Integrated Hospital and Bundling Studies** 

- 2008 “Examining Relationships In An Integrated Hospital System”
- 2009 “Examining Post Acute Care Relationships In An Integrated Hospital System”
 - Illustrate Medicare Patterns Of Care, Who Uses PAC, Types Used, Predictions Of Readmissions, Variations
- Provides Data For PAC Payment Reform
 - Case Mix Complexity/Severity Predicts Service Use/ Cost
- 2010 “Post Acute Care Episodes”



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 **Medicare’s Coverage Criteria: One Year Later – How Are You Doing?**






**Federal Register
August 7, 2009**

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 **For Your Toolkit:**  **CMS Resources Available on the New IRH/U Coverage Criteria**



- FY 2010 Final Rule (74 F.R. 39762), August 7, 2009
- Follow Up Information on New Coverage Criteria, Week of October 14, 2009
- Notice of Recission of HCFA 85-2, October 23, 2009
- Transmittal 112, Change Request 6699, October 23, 2009
- MedLearn Matters MM6699, Coverage of Inpatient Rehabilitation Services, October 27, 2009

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 **For Your Toolkit:** 
CMS Resources Available on the New IRH/U Coverage Criteria



- Provider Inquiry Assistance (JA 6699) Coverage of Inpatient Rehabilitation Services, October 27, 2009
- CMS Power Point Presentation, November 12, 2009 Provider Education Call
- CMS Audio and Transcript of November 12, 2009 Call Posted October, 2009
- IRF PPS Coverage Requirements November 12, 2009 National Call, Follow Up Series 1 (Q&A)12/17/09


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 **For Your Toolkit:** 
CMS Resources Available on the New IRH/U Coverage Criteria



- IRF PPS Coverage Requirements November 12, 2009 National Call, Follow Up Series 2 (Q&A) 12/18/09
- IRF PPS Coverage Requirements November 12, 2009 National Call, Follow Up Series 3 (Q&A) 1/4/10
- Transmittal 119 Change Request 6699, Rescinds Transmittal 112, Inpatient Rehabilitation Services (IRF), Revision to Chapter 1, Section 110 Medicare Benefit Policy Manual, (Pub. 100-02), January 15, 2010
- IRF PPS Coverage Requirements, November 12, 2009 National Call, Follow Up Session Series 4 (Q&A) 9/2010


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 **CMS' Intent –** 
Looking Through A Glass Darkly?

- To Place Providers and Contractors on the Same Footing in Interpretation
- Have Clear Criteria Clearly Understood
- Minimize Multiple Interpretations
- Lower Denials and Particularly Lower ALJ Reversals
- Focus on Decision Making Process on Admission and Status of the Patient
- Ideally Removing Stealth Criteria of Treat at Less Intensive Setting
- Is It Clear?



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 **What Does The Q And A Address?** 

- Use of Physician Extenders, Residents
- Details Regarding POC and Team Meeting
- Concern Regarding References to Group and Concurrent Therapy; Minutes
- Admission Orders
- What Doesn't It Answer?
- Has Your MAC or FI Done Any Provider Education?
- See Appendix





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 **Question To The Audience** 

What Further Question Does The New CMS Information Sheet Raise?


Please email me at czollar@amrpa.org and we will communicate with CMS

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 **Continuing Issues - Group Therapy Pg. 39796** 

- No Regulation Issued in Final Rule
- CMS Might "Issue Specific Standards"
- Standard is Individualized Therapy / One on One
- Group Is an "Adjunct" to Individual
- When Group Better Meets PT Needs on Limited Basis the Situation/ Rationale Must be Specified in the Medical Record
- AMRPA Work Group on Definitions – Group; One on One, Concurrent


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 **DOCUMENT IT!**


- Strategies
- Procedure
 - Pop Up Time Coded System to Alert When Next Steps Necessary After Admission?
- Checklists
 - Required Elements for the Record
 - Documentation To Be Included
 - Others




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 **DOCUMENT IT!**

- Internal Audits
- External Audits
 - Consultants
 - The Feds
- Be Legible, Clear!




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 **IRF-PPS**



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OIG Reports




1. Nationwide Review of Inpatient Rehabilitation Facilities Transmission of Patient Assessment Instruments for Calendar Years 2006 and 2007 (A-01-09-00507)
2. Review of IRF Compliance with Medicare Transfer Regulation FY 2004-2007 (A-04-09-00059)

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FY 2011 IRF PPS Changes




- Payment Rate From Adjusted FY 2010 - \$13,627 to \$13,860
- Updated CMS Weights and LOS
- Labor Share – From 75.779 to 75.271
- Outlier Threshold From Adjusted FY 2010 - \$10,721 to \$11,410
- Facility Adjusters: No Change From FY 2010
 - LIP – 0.4613
 - Rural – 18.4%
 - Teaching – 0.6876
- Also Includes Revised RCCs
- CMS Will Publish PRICER, Other Updates and Data

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Standard Payment Amounts



Year	Payment Rate	Percentage Change
FY 2002	\$11,838	
FY 2003	\$12,193	+3.0%
FY 2004	\$12,525	+2.7%
FY 2005	\$12,958	+3.5%
FY 2006	\$12,762	-1.5%
FY 2007	\$12,981	+1.7%
FY 2008	\$13,451	+3.62%
FY 2008 Adjusted	\$13,034	-3.10%
FY 2009	\$12,958	-5.830%
Final FY 2010	\$13,661	+5.43%
Adjusted FY 2010 per PPACA	\$13,627	-0.25
FY 2011	\$13,860	+1.70%


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75% Report To Congress

- Report to Congress – Sent Week of August 16
- Conclusions – No Recommendations
 - Diagnosis Doesn't Guarantee Needed for IRF Intensity
 - If Change Rule, Have to Ensure Availability of IRF Services
 - Intensity of Services Focus
- Doing Additional Analysis Using CARE Tool Data



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Impact of the Rule and Denials Well Known And Further Documented By MedPAC and eRehabData®

- Medicare FFS Patients Declining; No FFS Increase Post 60% Rule as Expected
- Cost Per Day and Per Discharge Increasing
- Non Medicare Including Medicare Advantage Patients Increasing
- Number of Beds Closing Faster Than Facilities Closing
- Drop in Payments
- Number of Units Still Declining
- Look At The Numbers

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State Of The Field

Results of Changes in Case Mix and Type of Cases

	2001	2003	2005	2007	2009-
Average Length of Stay Medicare ^a	14	12.8	13.1	13.2	13.55
Case Mix Index Medicare ^a	1	1.07	1.14	1.22	1.29
Tier Zero Percentage-Medicare		73.10%	70.80%	67.50%	61.70%
Discharged to Community Medicare ^a		77.00%	72.40%	71.40%	69.10%
Stroke Cases ^a	~20.0%	17.06%	19.67%	21.5%	22.19%
Joint Replacement	~22.0%	24.50%	22.52%	16.97%	13.09%

*MedPAC
^aeRehabData®
 ~All numbers eRehabData® (actual or interpolated)
 ** CMS OSCAR Reports to AMRPA


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 **Proposed MPFS CY 2010**

- Multiple Procedure Payment Reduction Policy (MPPR) for Always Therapy Codes
- 46 Codes Involved, Table 18
- Reduce PE of Lesser Expensive Code by 50% on Same Day Delivered
- Estimated to Reduce Therapy Payments by 12%; May Hit Providers Harder
- What Is Its Impact on You?
- AMRPA Working With a Coalition; Advocacy Alerts
- Fall Meetings with CMS and Congress

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 **Medicare Compliance Review Contractors**

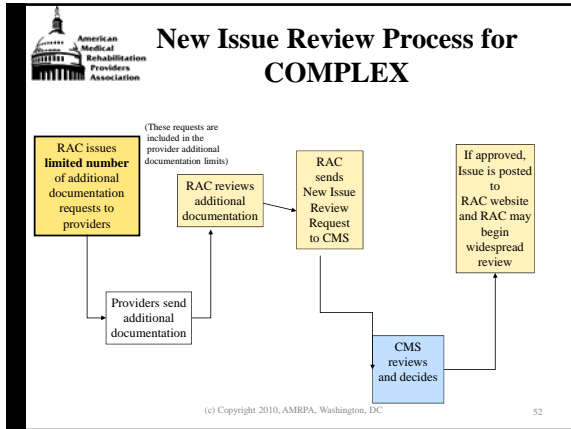


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 **TYPES OF RAC(K)S**



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-
- Where Are New Issues Posted?**
- Region A: Diversified Collection Services (DCS)
 - www.dcsrac.com (Provider Portal/Issues Under Review)
 - Region B: CGI Federal and CIGNA Government Services (CGS)
 - <http://racb.cgi.com> (Issues)
 - <http://www.cignagovernmentservices.com/jc/index.html>
 - Region C: Connolly Healthcare
 - www.connollyhealthcare.com/RAC (Approved Issues)
 - Region D: HealthDataInsights (HDI)
 - <https://racinfo.healthdatainsights.com> (New Issues)
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Example of New Issue Posting-DCS

Issue Name:	Duplicate Claims - Part B
Issue Number:	A000462009
Issue Description:	Providers should not bill duplicate claims. Therefore, an issue may exist when duplicate services are billed and reimbursed under Medicare Part B.
Type of Review:	Automated Review for Overpayments
State(s) Affected:	DC, CT, MA, MD, ME, DE, NJ, NY, NH, PA, RI, VT
Providers Affected:	Physician (Carrier) / Outpatient Hospital
Date Posted:	June 17, 2010
Dates of Service:	October 1, 2007 - Present
Issue References	IOM 100-04 Chapter 1, Section 120

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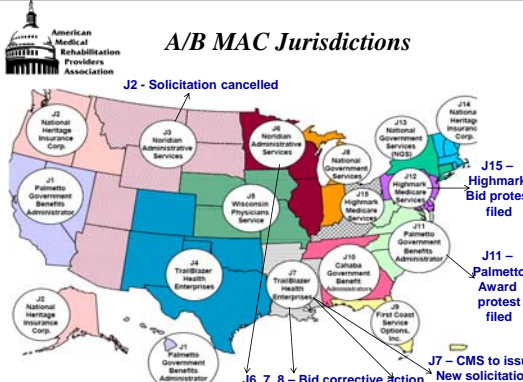
RAC Use of Pre Screening Criteria

- Milliman
 - Connolly, DCS
- Inter Qual?
- Problem: Denial of Access?
- What Have You Heard? CMS Wants Feedback



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A/B MAC Jurisdictions





Revised 9/1/10

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Cahaba Starts Pre Payment Reviews

- States Included: Alabama, Georgia and Tennessee
- AMRPA Has Heard of 4 Hospitals
- Focus on CMGs A-2001-2004 and A0801-0806
- Respond in 45 Days or Denied
- Issues:
 - Review of Group Therapy
 - Possibly Use SNF Definitions –Concurrent vs. Group


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PSCs/ ZPICs

- Health Insurance Portability and Accountability Act, 1996, Medicare Integrity Program
- Medicare Reviews, Cost Report Audits, Fraud Detection, Overpayments, Etc
- Report Findings to the OIG, HHS, Possibly FBI and DOJ
- Requesting IRH/U Records
- Coordinates with MACs
- Start with Data Mining and Analysis
- List of ZPICs/PSCs in Appendix


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And Now:

- Medicaid Integrity Contractors (MICs) for Medicaid
 - DRA 2005
 - MICs for Medicaid Fraud and Abuse
 - 2010- 18 States, not PA
 - After 2010- Includes PA



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Provider Self Disclosures: Tricky Area



- If a provider does a self-audit and identifies improper payments, the provider should report the improper payments to their claims processing contractor
- Initiated by OIG in 1998 Self Disclosure Protocol, 10/30/98 *F.R.* Notice, OIG Letter of 4/15/08 of Self Disclosure Protocol
- See Recent Mercy Hospital Settlement
- New Statutory Requirement for HHS to Develop a Self Disclosure Protocol
- **Tip:** Speak with Counsel regarding self disclosure

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 **For Your Toolkit:**
Current Appeals Rules 



- Interim Final Rule Issued 3/8/05
- Corrections 6/30 and 8/26/05
- Final Rule 12/9/09, Effective 1/8/10
- All Days Are Calendar Days
- If Due Date Falls on Sat, Sun, Holiday – “Roll Over”
- Time Frames Not Changed
- Terms – Clarifies “Final”, “Bundling”, “Decision”, “Dismissal”, “Remand” etc.


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 **For Your Toolkit:**
CMS Issuances on Recoupment 


- Final Rule, 9/18/09 Section 935(f) MMA, Effective 11/16/09
- Transmittal 141, September 2008 Rule is the Same
 - Business Judgment on Recoupment
 - To Prevent Recoupment Must File for Redetermination in 30 vs. 120 Days
 - To Prevent Recoupment Must File for Reconsideration in 60 vs. 180 Days

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 **For Your Toolkit:**
Updated Interest Rates 


- Transmittal 172, July 14, 2010
- 42 CFR §405.378 Provides for Assessment of Interest at the Higher of the Current Value of Funds Rate (One Percent for Calendar Year 2010) or the Private Consumer Rate as Fixed by the Department of the Treasury.
- Medicare Contractors Shall Implement an Interest Rate of 11% Effective July 21, 2010 for Medicare Overpayments and Underpayments. 

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AMRPA Actions

- eRehabData@ Appeals Database
- Appeal Denials Checklist: “How To Appeal”;
- AMRPA Tracking Spreadsheet
- Denial Survey
- Supporting FAIR Fund
- Calls with RAC Staff
- AMPRA Member Calls with RAC Staff




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Outpatient Research

- Developing Outpatient Therapy Alternatives (DOPTA)
 - 5 Years
 - New Outpatient Assessment Tool
 - CMS Is Now Recruiting Participants
- Short Term Alternatives For Therapy Services (STATS)
 - 2 Years
 - Looking For Payment Policy Change Away From Or In Addition To Exceptions Process
 - Move Away From Caps?


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ARRA HITECH

- 1/13/10 Interim Final Rule
- 1/13/10 Proposed Rule on Meaningful Use
- Medicare Incentive Payments
- Implications for Rehabilitation Hospitals and Rehabilitation Units May Be Different
- 6/24/10 Certification Programs for Health Information Technology Final Rule
- 7/28/10 Final Rules on Meaningful Use and Standards, Specifications and Certification Criteria for EHR Technology


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ARRA HITECH

- Beacon Communities
- State Health Information Exchange Contacts link:
<http://slhie.org/contact/participating-states-contact-information/>


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And Now for 2011?

- Continued Payment Reductions - “Bending the Cost Curve”
- Repeal of Parts of HCR?
- Continued Quality March – Yes!
- All Medical Necessity Reviews – RACs and MACs Move Forward
- Others?


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APPENDIX

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73




Patient Protection and Affordable Care Act, P.L. 111-148 and P.L. 111-152 Provisions Affecting IRH/Us

	PPACA, P.L. 111-148
Continuing Care Hospital	<p>Authorized as a bundling pilot (Section 10308).</p> <p>Allows the Secretary to test the CCH model through the Center for Medicare and Medicaid Innovation below Section 3021.</p>

March 25, 2010

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74




Patient Protection and Affordable Care Act, P.L. 111-148 and P.L. 111-152 Provisions Affecting IRH/Us

	PPACA, P.L. 111-148
IRH/Us Market Basket Update & Productivity Adjustment	<p>FY 2010 and 2011 MB – 0.25 %</p> <p>FY 2012 and 2013 MB - 0.1 %</p> <p>FY 2014 MB – 0.3%</p> <p>FY 2015-2016 - MB – 0.2%</p> <p>FY 2017-2019 - MB – 0.75%</p> <p>MB adjustment will be replaced with a 0.0 adjustment for any FY if the excess of the total percentage of the non-elderly insured population for the preceding fiscal year over the total percentage of the non-elderly insured population for such preceding FY exceeds five percent (Section 3401).</p>


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75

 **Patient Protection and Affordable Care Act, P.L. 111-148 and P.L. 111-152 Provisions Affecting IRH/Us**


PPACA, P.L. 111-148	
IRH/Us Market Basket Update & Productivity Adjustment <i>Cont'd</i>	<p style="text-align: center;"><i>Cont'd</i></p> <p>The IRH/U productivity adjustment <u>beginning in FY 2012</u> may result in the “increase factor” (MB minus productivity adjustment) being less than 0.0 and may also result in payment rates for a year being less than payment rates for the preceding year. In recent years, productivity has ranged between 0.8% and 1.3% (Section 3401).</p>

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 **Patient Protection and Affordable Care Act, P.L. 111-148 and P.L. 111-152 Provisions Affecting IRH/Us**


PPACA, P.L. 111-148	
Post Acute Care Bundling	<p>The Secretary would be required to develop, test and evaluate alternative payment methods through a national, voluntary pilot program designed to provide incentives for providers to coordinate patient care across the continuum and to be jointly accountable for the entire episode of care starting no later than 2013.</p> <p>Before January 1, 2016, the Secretary is also required to submit a plan to Congress to expand the pilot program if doing so will improve patient care and reduce spending (Section 3023).</p>

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 **Patient Protection and Affordable Care Act, P.L. 111-148 and P.L. 111-152 Provisions Affecting IRH/Us**


PPACA, P.L. 111-148	
Center for Medicare and Medicaid Innovation	<p>Establishes within CMS a Center for Medicare & Medicaid Innovation to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program. The Secretary could test the Continuing Care Hospital (CCH) model (Section 3021).</p>

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 **Patient Protection and Affordable Care Act,
P.L. 111-148 and P.L. 111-152 Provisions
Affecting IRH/Us**


PPACA, P.L. 111-148	
Extension of Therapy Caps Exceptions Process	One year extension (Section 3103).
Essential Benefits Package	Rehabilitation services are among the categories of the items and services covered in an essential benefits package (Section 1302).
Independent Medicare Advisory Board	The Board would make recommendations to the President, Congress, private companies and organizations annually on ways to improve quality and reduce the rate of cost growth in the private sector.

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 **Patient Protection and Affordable Care Act,
P.L. 111-148 and P.L. 111-152 Provisions
Affecting IRH/Us**

PPACA, P.L. 111-148	
	<i>Cont'd</i>
Independent Medicare Advisory Board	The Board would make recommendations to Congress in any year in which Medicare growth is below the targeted growth rate. Beginning in 2020, the Board would make binding biennial recommendations to Congress if the growth in overall health spending exceeds growth in Medicare spending (Section 3403).
VBP	The Secretary is required to test implementation of a VBP plan for select providers, including IRH/Us, no later than January 1, 2016. The Secretary is given authority to expand the program anytime after January 1, 2018, if certain factors are met (Section 10326).

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 **Patient Protection and Affordable Care Act,
P.L. 111-148 and P.L. 111-152 Provisions
Affecting IRH/Us**

PPACA, P.L. 111-148	
HAC	Beginning in FY2015 hospitals in the top 25th percentile for the rate of hospital acquired conditions for certain conditions would be subject to a payment penalty. Requires the Secretary to submit a report to Congress by January 1, 2012 regarding the appropriateness of establishing a policy for other providers, including IRH/Us and long-term care hospitals (Section 3008).
Recovery Audit Contractors	Extends the RAC program to Medicare Parts C and D and Medicaid (Section 6411).
Quality Measures	Sec 3004 starting FY 2014 if an IRH/U does not report data, 2% reduction taken after update and productivity reductions.

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 **Expanded Role for *Fraud and Abuse***




HHS Secretary Kathleen Sebelius and U.S. Attorney General Eric Holder

- August 26 - Hosts Second Regional Health Care Fraud Prevention Summit in Los Angeles
- July 16 - Kick-Off First Regional Health Care Fraud Prevention Summit in Miami, Florida
- July 15 - Announces New Tools to Help Fight Health Care Fraud in Florida
- June 8 - Sends Letter to State Attorneys General On New Outreach and Education Efforts to Combat Medicare Fraud
- New website: www.stopmedicarefraud.gov


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 **Expanded Role for *Fraud and Abuse***



- Expand RAC Program to Medicare A and Medicare Drug Program by 12/31/10
- Limits Claims Submission to 12 Months vs. 3 Years
- Covers Physician Ownership + Other Transparency

 **FBI** 



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 **Expanded Role for *Fraud and Abuse***

- Nursing Home Transparency Information
- CMPs Expanded; Increased
- Requires HHS To Establish a Self Disclosure Protocol
- Increases Program Integrity Funding
- Report and Repay Overpayment Within 60 Days After Date Identified
- June 14 –OIG Reports That Medicare Fraud Strike Force (HEAT) Activities Resulted in Convictions and Expected Recoveries
- For more information see <http://www.oig.hhs.gov/fraud/hotline/>



 **FBI** 

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 **What Did The Q And A Answer?** 



- **Physician Extenders - CMS spent considerable time in clarifying the use of physician extenders.**
- **Physician extenders may:**
 - Conduct the preadmission screening if they are licensed or certified and if they are appropriately trained and qualified to assess the patient's medical and functional status, assess the risk for clinical and rehabilitation complications and assess other aspects of the patient's condition both medically and functionally.

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 **What Did The Q And A Answer?** 



- **Physician Extenders May *cont'd***
 - Draft the reasoning/justification for the admission and make recommendations to the rehabilitation physician. However the rehabilitation physician must review and concur with the findings and result of the PAS. In defining physician extenders CMS references Section 1861(s) (2) (K) of the Social Security Act. This subparagraph references specifically physician assistants, nurse practitioners, or clinical nurse specialists working in collaboration with a physician.

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 **What Did The Q And A Answer?** 



- **Physician Extenders May *cont'd***
 - Complete the history and physical (H&P), however the rehabilitation physician must visit the patient and complete the other required parts of the post admission physician evaluation within 24 hours of admission.
 - Work in collaboration with the rehabilitation physician to assist the rehabilitation physician in developing the overall plan of care for the rehabilitation physician's approval and signature.
 - Work in collaboration with the physician to generate the admission orders.
 - See also §1861(aa) (5), (6) regarding the definition of clinical nurse specialist and collaboration respectively.

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 **What Did The Q And A Answer?** 


- **Residents**
- **CMS also addresses in part how residents may be used to meet the coverage criteria as well; however some others areas are not yet clear. Residents may:**
 - Conduct the preadmission screenings if they meet the criteria CMS has set for training, assessment of the patient's condition and risk for complications and other medical and functional aspects of the patient's condition and other tasks qualified physician extenders may perform as noted above.
 - Complete the H&P. In discussing its position that physician extenders and residents may complete the H&P it states that the "usual Medicare regulations" apply without a specific reference.

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 **What Did The Q And A Answer?** 



- **Residents May cont'd**
- Issue admission orders (as distinct from reviewing and concurring with the preadmission screening assessment) in that CMS states "Any licensed physician may generate the admission orders. It does not have to be a rehabilitation physician." CMS also states that a physician extender, working in collaboration with the physician, may generate the admission orders.
- Per conversations with CMS, residents may not lead team meetings or conduct the required rehabilitation physician three visits per week or other rehabilitation physician required responsibilities, unless the supervising rehabilitation physician is present. CMS sees residents as physicians in training.

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 **Transmittal 696 – Medicare Advantage Info Only Claims**

- 5/5/2010, CR 6821
- Must File Info Only Claims for Med A Patients in FYs 2007 and FY 2008
- Helps Calculate SSI Ratios
- Affects LIP Payments
- File by 8/31/2010


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**Transmittal 696 –
Medicare Advantage Info Only Claims**

- Attest by 9/15/2010
- The Transmittal is: “Transmittal 696, Requirements for Hospital Attestation and Billing of Fiscal Year 2007 and 2008 Informational Only Inpatient Claims for Medicare Advantage Beneficiaries,” May 5, 2010, CR 6821, available at <http://www.cms.gov/transmittals/downloads/R696OTN.pdf>.


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**RAC Documentation Limits for FY 2010
for Institutional Providers**

- Posted 1/28/10
- Are Per Campus Limit per 45 Day Period
- Limit Based on Campus Unit’s Prior Medicare Claims Volume
- Based on TIN and ZIP
- Limit Set at 1% of CY 2008 Claims Divided into 8 Periods (45 Days)


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**RAC Documentation Limits for FY 2010
for Institutional Providers**

- Two Caps:
 - Through 3/10 (2nd requests)
 - 4/10-9/10
 - 300 requests per campus per 45 days of bill in excess of 100,000 per TIN for all claims processing contractors
 - In FY 2010 CMS will allow the RACs to request permission to exceed the cap. Permission to exceed the cap cannot be requested in the first six (6) months of the fiscal year. The expanded cap will not be automatic; the RACs must request approval from CMS on a case-by-case basis and affected providers will be notified prior to receiving additional requests.


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Nationwide Switch to ICD-10 

- Additional information about GEMs was provided on the following CMS sponsored conference call - May 19, 2009, "ICD-10 Implementation and General Equivalence Mappings". Go to http://www.cms.gov/ICD10/02c_CMS_Sponsored_Calls.asp, scroll to the bottom of the page, under Downloads select – 2009 ICD-10 Conference Calls to locate the audio and written transcripts.


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Nationwide Switch to ICD-10 

- **Frequently Asked Questions (FAQs)** – Access <http://www.cms.gov/ICD10/>, select the Medicare Fee-for-Service Provider Resources link from the menu on the left side of the page, scroll down the page to the "Related Links Inside CMS" section and select "ICD-10 FAQs".

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Nationwide Switch to ICD-10 


MLN Matters® Number: SE1019

- On October 1, 2013, medical coding in the U.S. health care settings will change from ICD-9-CM to ICD-10.
- CMS will implement the ICD-10-CM (diagnoses) and ICD-10-PCS (inpatient procedures) at the same time.
- ICD-10-CM diagnoses codes will be used by all providers in every health care setting.
- ICD-10-PCS procedure codes will be used only for hospital claims for inpatient hospital procedures.
- The compliance dates are firm.

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ZPICs To Date




ZPIC	Zone	Parts A, B, HH + H, DME
	1	California, Nevada, American Samoa, Guam, Hawaii, Mariana Islands
	2	Alaska, Washington, Oregon, Montana, Idaho, Wyoming, Utah, Arizona, North Dakota, South Dakota, Nebraska, Kansas, Iowa, Missouri
	3	Minnesota, Wisconsin, Illinois, Indiana, Michigan, Ohio, Kentucky
Health Integrity	4	Texas, Oklahoma, Colorado, New Mexico

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ZPICs To Date




ZPIC	Zone	Parts A, B, HH + H, DME
AdvanceMed Corp.	5	West Virginia, Virginia, North Carolina, South Carolina, Georgia, Alabama, Mississippi, Tennessee, Arkansas, Louisiana
	6	Pennsylvania, New York, Maryland, Washington D.C., Delaware, Maine, Massachusetts, New Jersey, Connecticut, Rhode Island, New Hampshire, Vermont
SafeGuard Services	7	Florida, Puerto Rico, Virgin Islands

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PSC To Date





PSC	Task Order Name	Jurisdiction
AdvanceMed Corporation	Ohio / Kentucky / Minnesota PSC	<u>Part A&B</u> : Kentucky and Ohio
		<u>Part A</u> : Minnesota
Cahaba Safeguard Administrators	North Carolina PSC	North Carolina Cost Report and Medical Review Activities for Part A Facilities
Cahaba Safeguard Administrators	Alabama	<u>RHHI</u> : Montana, Wyoming, Utah, Colorado, North Dakota, South Dakota, Nebraska, Kansas, Iowa, Missouri, West Virginia



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 PSCs To Date 		
PSC	Task Order Name	Jurisdiction
Computer Sciences Corp.	Western Integrity Center (WIC)	Part A: North Dakota, Alaska, Washington, Oregon, Utah, Montana, Wyoming, Idaho, Arizona, South Dakota, Iowa
		Part B: Alaska, American Samoa, Arizona, Guam, Hawaii, Iowa, Nevada, North Dakota, Oregon, South Dakota, Montana, Idaho, Wyoming, Utah
IntegriGuard, LLC	NE, KS, MO & WPS	Part A & B: Nebraska, Kansas, and Missouri
		Part A: BI work currently performed by WPS

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 PSCs To Date 		
PSC	Task Order Name	Jurisdiction
Safeguard Services (SGS)	New England Benefit Integrity Support Center (NE - BISC)	Part B: Maine, Massachusetts, New Hampshire, Rhode Island, Vermont, Connecticut, DC, Delaware, Maryland
		Part A: New Hampshire, Rhode Island, Vermont, Maine, Massachusetts, Connecticut, DC, Maryland, Delaware
		RHHI: Connecticut, Massachusetts, Maine, New Hampshire, Rhode Island, Vermont, DC, Maryland, Delaware, Pennsylvania

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 PSC To Date 		
PSC	Task Order Name	Jurisdiction
Safeguard Services (SGS)	California Benefit Integrity Center (CAL - BISC)	Part B: California
Safeguard Services (SGS)	Eastern Benefit Integrity Center	Part A and B: New York and New Jersey
Safeguard Services (SGS)	PENN-Benefit Integrity Center	Part A and B: Pennsylvania
Safeguard Services (SGS)	Region D - Durable Medical Equipment (DME) PSC	DME: Alaska, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming, Mariana Islands, and American Samoa

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PSC To Date

PSC	Task Order Name	Jurisdiction
TriCenturion	Region A/B - Durable Medical Equipment (DME) PSC	<u>DME</u> : Connecticut, Delaware, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, District of Columbia, Illinois, Indiana, Maryland, Michigan, Minnesota, Ohio, Virginia, West Virginia, and Wisconsin.

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PSC To Date

PSC	Task Order Name	Jurisdiction
Trustsolutions, LLC	UGS Workload, WPS Workload, ASF Workload	<u>Part A</u> : American Samoa, California, Guam, Nevada, Hawaii, Mariana Islands, Michigan, Wisconsin, Illinois, and Indiana <u>Part B</u> : Minnesota, Wisconsin, Michigan, Illinois, and Indiana <u>RHHI</u> : American Samoa, Mariana Islands, Oregon, California, Nevada, Idaho, Arizona, Hawaii, Guam, New Jersey, New York, Wisconsin, Michigan, Minnesota, Alaska, and Washington, Illinois, Indiana, Kentucky, Ohio <small>107</small>
