



***Regulatory Requirements and Pearls for
IRH/U Medical Directors
2010 and Beyond***

***AMRPA 8th Annual Medical
Rehabilitation Education Conference
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Who Might Be Interested?

- For Those Directors New to Medical Inpatient Hospital Rehabilitation
- For Those Who Want to Refresh Their Knowledge About Basics
- For Those Seeking Insight Into the Rules
- A Separate Language Is Required



Simply Put Medical Directors:



- Have Specific Responsibilities Under the Exclusion Criteria
- Do Not Have Specific Responsibilities Under the Coverage Criteria But Do If Acting as Rehab Physician; If Expected by the Hospital In a Supervisory Role
- Play a Key Role Along With All Rehab Physicians in Assuring Proper Case Documentation for Complete IRF PAI Coding and CMG/Tier Assignment
- Helps In Appealing Denials



Key Questions To Be Addressed



- **Definition and Exclusion:** What is a Rehabilitation Hospital/Unit (and How Many Times) Is It Defined?
- **Coverage:** What Are the Medicare Coverage Requirements? Why Do They Exist? Who Defines Them?
- **Payment:** How Are Medical Rehabilitation Services Paid for by Medicare?
- To Which of These Should Medical Directors Pay Attention?

Develop a “Tool Kit”

- For Reference With All the Basic Documents for Exclusion Coverage, and Payment
- Special Focus on Medical Directors Responsibilities; Responsibilities of Rehab Physicians Who Aren't Medical Directors



Items For Your Toolkit

1. Classification (Exclusion) Criteria

- **Pre 1/1/2010**
 - 42 CFR 412.23
 - 42 CFR 412.25
 - 42 CFR 412.29
 - 42 CFR 412.30



Items For Your Toolkit

1. Classification (Exclusion) Criteria

- **Post 1/1/2010 Version**

(Published in August 7, 2009 *Federal Register*)

- 42 CFR 412.23
- 42 CFR 412.29
- N.B. No Change to 42 CFR 412.30 or
42 CFR 412.25



Items For Your Toolkit

1. Classification (Exclusion) Criteria

- Rehabilitation Hospital and Unit Worksheets
- State Operations Manual Section 3100 et. seq. on Excluded Hospitals
- Multiple CMS Transmittals on the 60% Rule, See Particularly Transmittal 938 (C.R. 5016, May 5, 2006)



Items For Your Toolkit

2. Coverage Documents

- HCFA Ruling 85-2
- MBPM Section 110 – Pre 1/1/2010
- MBPM Section 110 Effective Post 1/1/2010
- 42 CFR 412.622 (a)(3) et. seq. Effective 1/1/2010



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



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



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



Items For Your Toolkit

3. IRF PPS Documents

- Section 1886 (j) Social Security Act
- 42 CFR Subpart P, 412.600 et. seq.
- IRF PAI Training Manual
- Annual SSI , Comorbidity etc., Updates on CMS Website
- UB Billing Form
- CMS IRF PPS website –
www.cms.gov/inpatientrehabfacpps/



Items For Your Toolkit

3. IRF PPS Documents *cont'd*

- Be Familiar With:
 - FY 2002 Final Rule, August 7, 2001 – The Original Payment System
 - FY 2006 Final Rule, September 30, 2005 (FY 2006 Refinements)



Classification (Exclusion) Criteria- Rehabilitation Hospitals And Units (IRH/Us)

What Is an IRH/U?



A Quick Review - Definition Of A Rehabilitation Hospital Or Unit



- Rehabilitation Hospital Defined in Original Medicare Law, Section 1861(e)(2)(1)(B)
 - “ The Term “Hospital”means an institution which (1) is primarily engaged in providing, by or under the supervision of physicians to inpatients....(B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;.....



Definition of Rehabilitation Hospitals and Units Under TEFRA

- All Excluded Hospitals Are Defined By Law For This Purpose Except Rehab: Section 1866(d)(1)(B)(ii)
 - Secretary Must Define By Regulation
- Secretary Issues Rehab Exclusion Criteria 1/84
 - 42 CFR 412.23(b), .25, .29,.30
 - Purpose: To Distinguish From Acute Hospitals



Medicare PPS Exclusion Criteria

- How Differ From Coverage Criteria?
 - Coverage Criteria Determine if You Get Paid for the Stay
 - Classification Criteria Determine Whether PPS Excluded or Not
- Exclusion Criteria Distinguish IRFs from Acute Hospitals
 - Are Paid Under the Inpatient Rehabilitation Facility Prospective Payment System (IRF-PPS) vs. MS DRGs



Medicare PPS Exclusion Criteria Cont'd

- Annual Review by State Health Department and 2 Criteria by FI
- Apply at Start of CRP
- Speaks to Medical Director Not Rehab Physician
- What Happens If Lose Exclusion?

Classification Criteria

42 CFR 412.23 (b)

OLD	NEW Effective for Discharges on or after 1/1/10
1. Participation Agreement	1. No Change
2. 60% Rule	2. No Change
3. Preadmission Screening Procedure	3. Reframed to Delete “Assessment” (e.g. No 3-10 Day Stay
4. Close Medical Supervision	4. Slightly Rephrased to say “social services, psychological services (including neuro psychological services)” ; all others retained

Classification Criteria

42 CFR 412.23 (b)

OLD	NEW Effective for Discharges on or after 1/1/10
6. Plan of Treatment	6. No Change
7. Coordinated Multidisciplinary Team	7. Replaced with reference to interdisciplinary team and team meetings once a week
8. Attestation for New Hospitals on 60% Rule	8. No Change
9. Retroactive Payment Adjustment	9. No Change



42 CFR 412.23(b) – Rehabilitation Hospital

1. Have a hospital provider agreement with medicare pursuant to part 489
2. Meet the 60% rule

42 CFR 412.23(b) – Rehabilitation Hospital

3. Have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program



Exclusion Criteria

42 CFR 412.23(b) – Rehabilitation Hospital

4. Ensure that the patients receive close medical supervision and furnish, through the use of qualified personnel, rehabilitation nursing, physical therapy, and occupational therapy, plus, as needed, speech-language pathology, social services, psychological services (including neuropsychological services), and orthotic and prosthetic services.

Exclusion Criteria

42 CFR 412.23(b) – Rehabilitation Hospital

5. Director of rehabilitation
 - Full time
 - Doctor of medicine or osteopathy
 - Licensed under state law
 - Has had, after completing a one year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services



Exclusion Criteria

42 CFR 412.23(b) –

Rehabilitation Hospital

6. Have a plan of treatment established, reviewed and revised, as needed, by a physician in consultation with other professional personnel who provide services to the patient



Exclusion Criteria

42 CFR 412.23(b) –

Rehabilitation Hospital

7. Use a coordinated interdisciplinary team approach in the rehabilitation of each inpatient, as documented by the periodic clinical entries made in the patient's medical record to note the patient's status in relationship to goal attainment, and that team conferences are held at least once per week to determine the appropriateness of treatment.



42 CFR 412.23(b) - Rehabilitation Hospital

8. A hospital that seeks classification as a rehabilitation hospital for the first full 12-month CRP that occurs after it becomes a Medicare-participating hospital may provide a written certification that the inpatient population it intends to serve meets the 60% rule, instead of showing that it has treated that population during its most recent 12-month cost reporting period. The written certification is also effective for any cost reporting period of not less than one month and not more than 11 months occurring between the date the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.



42 CFR 412.23(b)- Rehabilitation Hospital

9. For cost reporting periods beginning on or after October 1, 1991, if a hospital is excluded from the prospective payment systems [IPPS] or is paid under the prospective payment system specified in 412.1 (a) (3) for a cost reporting period under paragraph (b)(8) of this section, but the inpatient population is actually treated during that period does not meet the requirements of paragraph (b)(2) of this section, we adjust payments to the hospital retroactively...



Medicare Advantage Patients Added to Compliance Calculation for the 60% Rule

- For cost reporting periods beginning on or after July 1, 2005, the hospital has served an inpatient population of whom at least 60 percent required intensive rehabilitative services for treatment of one or more of the conditions specified in paragraph (b)(2)(ii) of this section.
- Patients with comorbidities may qualify.
- Effective 10/1/09 Medicare Advantage patients can be included in the calculations, esp. for presumptive methodology.



Other Hospital Exclusion Criteria

412.22

- DRGs Do Not Apply to Hospitals in a State Cost Control Program
- Changes in Exclusion or Not Effective at Start of CRP Only
- Changes in Classification Effective Only at Start of CRP
- Hospitals-Within-Hospitals
- Satellite Facilities

Other Exclusion Criteria

- Common Requirements for Rehab and Psychiatric Units, 42 CFR 412.25(a)
- Specific Requirements for Rehab Units, 42 CFR 412.29
- New Units, Converted Units, Expansion of Units
Decrease in Beds, 42 CFR 412.30
- Change in Status of Units, Change in Size of Units
(Decrease or Increase in Size, 42 CFR 412.25(b))
- Satellite Facilities, 42 CFR 412.23(e)
- Changes in Classification, 42 CFR 412.25(f)

How Does CMS Do This?

- CARF or JCAHO Accreditation – Deemed for All Except Medical Director and 60% Rule
- State Health Department - Uses Hospital and Unit Criteria Work Sheets
- FIs Responsible for Verifying Medical Director and 60% Rule
- Performed Annually to Assure Compliance with the Current CRP and Findings Applicable to Next CRP



Rehab Unit and Hospital Criteria Worksheet

- Used By State Agency
- Have Guidance For Each Criteria
- FI Does 60 % Rule And For Units All Accounting (412.25(a) (8-12))
- Medical Directors Hours Include Administrative and Direct Patient Care
- No Use of PAs or Other Extenders
- See State Operations Manual

State Agency Action

State OPS Manual Sec. 3106C

- If the Facility Has CARF or JCAHO Accreditation, CMS Presumes Compliance With All Exclusion Criteria Except:
 - 60% Rule
 - Medical Director
 - “If the Rehabilitation unit serves both inpatients and outpatients through a single, integrated unit, the time spent by the director in performing administrative duties for the entire unit counts towards the time requirement. The SA does not prorate this administrative time between inpatients and outpatients. However, time devoted to performing direct patient care can count toward the time requirement only if furnished to inpatients of the unit.”



What Happens If You Don't Meet The Exclusion Criteria One Year?

- New Facilities
 - Pay Back the Difference
 - Units With New Beds Pay Back the Difference Too
 - Ouch!

- Older Facilities
 - Lose Exclusion for the Subsequent CRP



What Are Your Responsibilities From Medicare's Perspective ?:

Requirements For Medical Directors In PPS Excluded Rehab Hospitals And Units

- Time
 - Freestanding Hospitals – 35 Hours/ Week
 - Units – 20 Hours/Week
 - Will Review Time Cards, Logs, etc.
- Education/Training
- Is MD or DO
- Licensed By The State
- After One Year Internship Has At Least 2 Years Training or Experience in Medical Management of Inpatients Needing Rehabilitation Services





Requirements For Medical Directors In PPS Excluded Rehabilitation Hospitals And Units

- Provide Close Medical Supervision
- Multidisciplinary Team e.g. Team Conference
- Which Hours Count – Part A and Part B

Medicare Coverage Criteria (Slight Schizophrenia Still Helps)

- Who Is Allowed In The Rehabilitation Hospital/ Unit?

Inpatient Rehabilitation
Hospital/Unit



Medicare Law



- Section 1862 (a) (1) (A)
“No payment will be made for items or services which are not reasonable or necessary for the diagnosis or treatment of illness, injury, or to improve the function of a malformed body member...”



Medicare Coverage Criteria

Pre Jan. 1, 2010

- Why Be Concerned About Old Regulations?
- Developed by CMS and the Field Years Ago
- Set Forth Requirements To Be Met for Patients for Inpatient Hospitals Stays for Medical Rehabilitation to Be Covered by Medicare
- LCDs Come Into Play Here Too
- Contractors Can Still Review Cases Pre 1/1/10 Esp. RACs



Medicare Coverage Criteria: Who Enforces It

- PROs - and QIOs Initially
- Medical Review Authority Given to FIs in Program Trans. 21 - 2/28/02, Contractors “May” Do Reviews, Revised Trans. 25 - 4/25/02
- Recovery Audit Contractors
- Program Safeguard Contractors/Zone Program Integrity Contractors



Medicare Coverage Criteria

- Purpose: To Decide Which Patients are Medically Necessary to Treat in A Rehab Hospital/Unit
- Medicare Benefit Policy Manual (Pub. 100-2)
Chapter 1, Section 110, “*Inpatient Hospital Stays for Rehabilitation Care*”



Medicare Coverage Criteria Through 1/1/2010

- HCFA Ruling 85-2, 7/3/85 “*Criteria for Medicare Coverage of Inpatient Hospital Rehabilitation Services*” (For Discharges Before 1/1/10)
- All Rehabilitation Patients Must Meet These Criteria Be They Within “60% Rule” or Not
- Some Differences Between HCFA 85-2 and Section 110, MBPM
- In Appeals ALJs Relied on HCFAR 85-2 To Date



Medicare Coverage Criteria: Post Jan. 1, 2010

- Completely Rewritten Section 110, Medicare Benefit Policy Manual
- 42 CFR Subpart P, 412.622 (a)(3) et. seq., Basis for Payment, IRF Coverage Criteria for Discharges On or After 1/1/2010
- Four Sets of Information Sheets



As Medical Directors You May Be Asked To:

- Review Rehab Physician's Documentation
- Participate in In House Training on New Criteria
- Help Prepare Appeals for Cases Both Pre and Post 1/1/10
 - Review Physician Documentation
 - Draft Appeal Letters on Point Showing How Close Medical Supervision Occurred
 - For Post 1/1/10, Review How All Requirements for Rehab Physician Were Met and Other Requirements

Three Key Criteria In Current Appeals for Cases Pre Jan. 1, 2010

- Close Medical Supervision By Qualified Physicians
- 24/7 RN Availability With Specialized Training or Experience in Rehabilitation
- Relatively Intense Level of Rehab
- Focus on HCFA Ruling 85-2 For Appealing Denials





Definition of Medical Supervision

HCFA 85-2

- Close medical supervision by a physician with specialized training or experience in rehabilitation -A patient's condition must require the 24-hour availability of a physician with special training or experience in the field of rehabilitation. This need should be verifiable by entries in the patient's medical record that reflect frequent and direct and medically necessary physician involvement in the patient's care; i.e., at least every 2-3 days during the patient's stay. This degree of physician involvement, which is greater than would normally be rendered to a patient in a SNF, is an indicator of a patient's need for, services generally available only in a hospital setting. A SNF patients care would usually require only the general supervision of a physician, rather than the close supervision which hospital patients need.



HCFA 85-2 Relatively Intense Level of Rehabilitation

- A relatively intense level of physical therapy or occupational therapy and, if needed speech therapy, social services, psychological services, or prosthetic - orthotic services -The patient must require at least 3 hours a day of physical and/or occupational therapy, in addition to any other required therapies or services, in exceptional cases, an inpatient hospital stay for rehabilitation care can be covered even though the patient has a secondary diagnosis or medical complication that prevents him from participating in programs of physical or occupational therapy to the extent outlined above.



HCFA 85-2 Relatively Intense Level of Rehabilitation

- Inpatient hospital care in these cases may be the only reasonable means by which even a low intensity rehabilitation program can be safely carried out. Documentation must be secured of the existence and extent of complicating conditions affecting the carrying out of a rehabilitation program to ensure that inpatient hospital care for less than intensive rehabilitation care is actually needed. [emphasis added]



Medicare Medical Rehabilitation Coverage Criteria Comparison

OLD - HCFAR 85-2	NEW - 42 CFR 412.622(a)(3)-(5)
A. General	Deleted
B. Readmission Screening	(a)(4)(i) – Rewritten completely and is now mandatory
C. Inpatient Assessment of Potential <ul style="list-style-type: none"> • 3-10 Day Evaluation Assessment • Will Cover Even When Deemed Not To be a Candidate 	(a)(4)(i)(ii) and (iii) Assessment is a new requirement and is a specified part of the Preadmission Assessment, Post-Admission Evaluation and Individualized Plan of Care 3-10 Day Evaluation Stay Eliminated; Admissions Found Not To Be Appropriate Will Be Paid the Short Stay CMG (CMG 5001)
D. Inpatient Rehabilitation Care 1. Close Medical Supervision by a Physician With Training and Experience in Rehabilitation	42 CFR 412.622(a)(3)(iv) Close Medical Supervision This criteria is rewritten with more responsibility going to the rehab physician Minimum of 3 face to face patient visits per week ₅₁

Medicare Medical Rehabilitation Coverage Criteria Comparison

<p style="text-align: center;">OLD HCFAR 85-2</p>	<p style="text-align: center;">NEW 42 CFR 412.622(a)(3) et. seq.</p>
<p>2. 24 Hour Rehab Nursing</p>	<p>Deleted and mention of rehab nurses included in new classification criteria and interdisciplinary team Preamble in 8/7/09 FY 2010 IRF PPS Final Rule emphasizes CMS recognition of role of rehab nurses</p>
<p>3. Relatively Intense Rehab Services – 3 Hour Rule</p>	<p>Rewritten extensively Not a “Rule of Thumb” Four (4) Qualifying Therapies Specified – PT, OT, CPP, P+O Flexibility Added 3 hours, 5 days a week or With documentation, 15 hours over 7 consecutive days Role of Aides Mentioned in Preamble</p>
<p>4. Multidisciplinary Team</p>	<p>42 CFR 412.622 (a)(5) – New Interdisciplinary Team with Specific Responsibilities Stated. Must Meet Formally at Least Once a Week</p>



Medicare Medical Rehabilitation Coverage Criteria Comparison

<p style="text-align: center;">OLD HCFAR 85-2</p>	<p style="text-align: center;">NEW 42 CFR 412.622(a)(3) et. seq.</p>
<p>5. Coordinated Program of Care</p>	<p>42 CFR 412.622(a)(4)(iii) New Individualized Overall Plan of Care Developed by Rehab Physicians Team Input within 4 Days of Admission Part of Medical Record</p>
<p>6. Significant Practical Improvement</p>	<p>See 42 CFR 412.622 (a)(3)(ii)(iv) regarding benefiting from therapy</p>
<p>7. Realistic Goals</p>	<p>Deleted; See 42 CFR 412.622(a)(5) regarding reference to stated rehab goals</p>
<p>8. Length of program</p>	<p>Deleted</p>

Conflict of Guidelines

- Which One “Wins” for Cases Discharged Before January 1, 2010?
 - HCFA 85-2
 - Unamended Section 110 MBPM



IRF NEW COVERAGE CRITERIA TIME LINE*

EFFECTIVE FOR DISCHARGES ON OR AFTER JANUARY 1, 2010

Time	Action
<ul style="list-style-type: none"> ● 48 Hours Prior to Admission 	Preadmission Screening If Done Before 48 Hours (Allows Flexibility For An Update)
<ul style="list-style-type: none"> ● Within 24 Hours Of Admission 	Rehabilitation Physician To Conduct Post Admission Evaluation
<ul style="list-style-type: none"> ● By End Of The 4th Day Following Admission 	Individualized Plan Of Care Must Be Completed By The End Of The Fourth Day Following Admission To The IRF
<ul style="list-style-type: none"> ● 1st Meeting Within A Week Of Admission, Weekly Thereafter 	Interdisciplinary Team Meeting
<ul style="list-style-type: none"> ● 3 Times A Week Minimum 	Rehabilitation Physician To See Patient; Reason Is To Reassess Patient
<ul style="list-style-type: none"> ● Within 36 Hours From Midnight Of Day Of Admission 	Initial Therapy; Includes Evaluations

*However, read the preamble to the FY 2010 Final Rule for details as published in the *Federal Register* dated August 7, 2009.

For Medical Directors Under New Criteria

- New Criteria Does Not Say Medical Directors Is Responsible
- New Criteria Says Rehabilitation Physician
- Therefore the Medical Director
 - May Be One of The Rehab Physicians
 - May Be Responsible for Assuring Training and Compliance of Other Rehab Physicians
- Depends on Arrangement with Provider





Responsibilities of Rehab Physicians Under New Criteria Are Greatly Expanded

- Pre Admission Screening
 - Review and Concur
 - How? By Fax, Email, Verbal, All?
 - When? 48 Hours Prior To Admission
- Admission Orders
 - How?
 - When? Before Deliver Therapy
- Post Admission Evaluation
 - When? 24 Hours After Admission



Responsibilities of Rehab Physicians Under New Criteria Are Greatly Expanded

- 3x Week Minimum Physician Visits
- Individualized Plan of Care
 - When? Within 4 Days of Admit
 - Who? Rehab Physician Has Responsibility
- Interdisciplinary Team Conferences
 - When? Within 7 Days of Admission
 - Who? Rehab Physician Leads

Document It!



Now and In The Future



Excellent Documentation for the Key Criteria Is Critical for Later Success

- Staring With the First Referral Call or Contact
- The Rehab Physicians Play a Critical Role in Documentation
- Develop a Team Process for Comprehensive Documentation





Excellent Documentation for the Key Criteria Is Critical for Later Success

- The Team Touches On All Parts of the Hospital/Unit
 - Coders/Medical Records
 - Administrators
 - Physicians
 - Therapists
 - Nurses
 - Finance
 - Who Else?





Excellent Documentation for the Key Criteria Is Critical for Later Success cont'd

- Make Sure It Is Legible By Hand or Electronically
- Meet Regularly to Review All Documentation Procedures
- Laminate the Old and New Criteria



Physician Documentation - Minimum

- Physician Notes, History and Physical and Evaluation Are Paramount
- Need To Document Your Thinking Process
 - How You Arrived At A Decision
 - What Was Done
 - What It Accomplished
 - Order for Intervention to Prevent DVT
 - Why Decide On The Order
 - Result: No DVT





Physician Documentation

- Example: Want To Avoid UTI, Don't Know If Present on Admission
 - Order Urinalysis
 - Result is Negative
 - Avoided Cost and Effect of Antibiotic
 - Avoided Effect and Overuse of Antibiotics
 - Write All 4 Points Down





Helpful Key Words to Support Medical Necessity

- Appropriate
- Continued
- Critical
- Gains
- Improvement
- Managing
- Motivated
- Progress
- Responsive
- Safety issues
- Significant
- Increase function
- Required therapist's skills
- Reasonable and necessary
- Safe and effective delivery
- Medical complications
- Reasonable probability
- Potential for complications
- High risk factor
- Risk of infection
- Prior level of function
- The patient has the potential for a sudden change in status

Words To Avoid

- Chronic/ long term condition
- Combative
- Conditioning/
Reconditioning
- Custodial
- Decline in function
- Demented/ Confused
- Inability to follow directions
- Inappropriate
- Insignificant
- Low rehab potential
- Maintained
- Monitoring
- Non compliant
- Normal
- Old onset
- Plateau
- Refused to participate
- Stable

Also Document

- All Interventions and Outcomes
- Detailed Program Notes With Objective vs. Subjective Statements
- Mrs. Jones Ambulated with a Walker 15 Feet Today with Moderate Assist; Yesterday It Was 10 Feet With Moderate Assist
- Not: Mrs. Jones is Walking Better

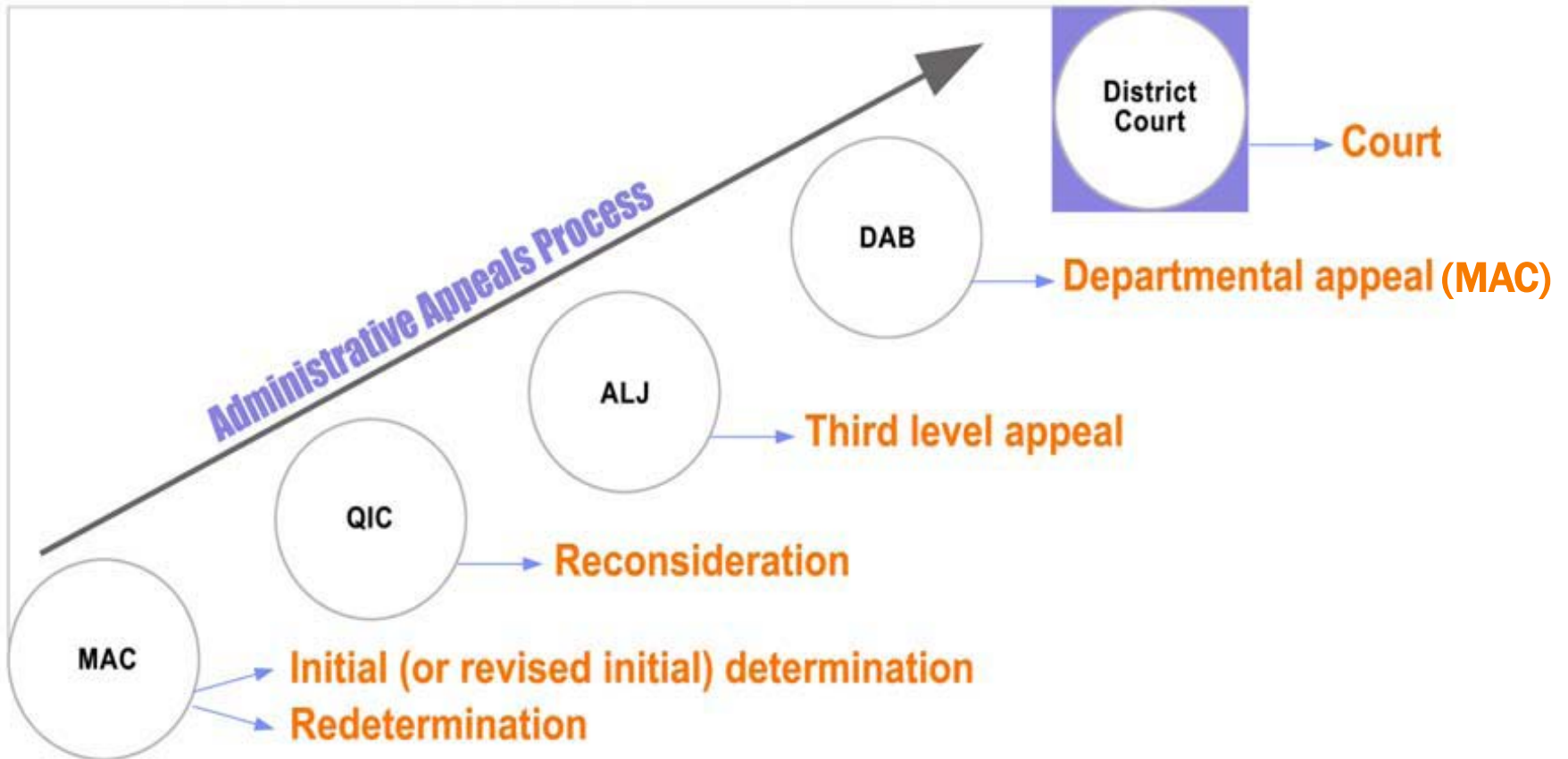




Medicare Compliance Review Contractors



Claims Appeals





Traditional Appeals Process

Level of Denial	Time in Which to File Response (Provider)	Time in Which to Make a Decision (FI, AIC, ALJ, etc)	Amount in Controversy Required
Initial ADR Request (Probe, Post Payment Review)	Usually 30 Days	N/A	N/A
Rebuttal	15 Days From Denial	15 Days	N/A
1. Redetermination of Initial Denial (Probe, Payment Review, LCD or RAC)	120 Days From Date of Receipt of Remittance Advice From FI	MAC Has 60 Days	N/A
2. Reconsideration by QIC	180 Days From Date of Receipt of Letter of Denial of Determinations	QIC Has 60 Days	None
3. ALJ Hearing	60 Days From Date of Receipt of QIC Decision	ALJ Has 90 Days	\$130
4. Department Appeals Board/MAC	60 Days After Date of Receipt of ALJ Notice ¹	90 Days	No Mention
5. Federal District Court	60 Days to File	None	\$1,260

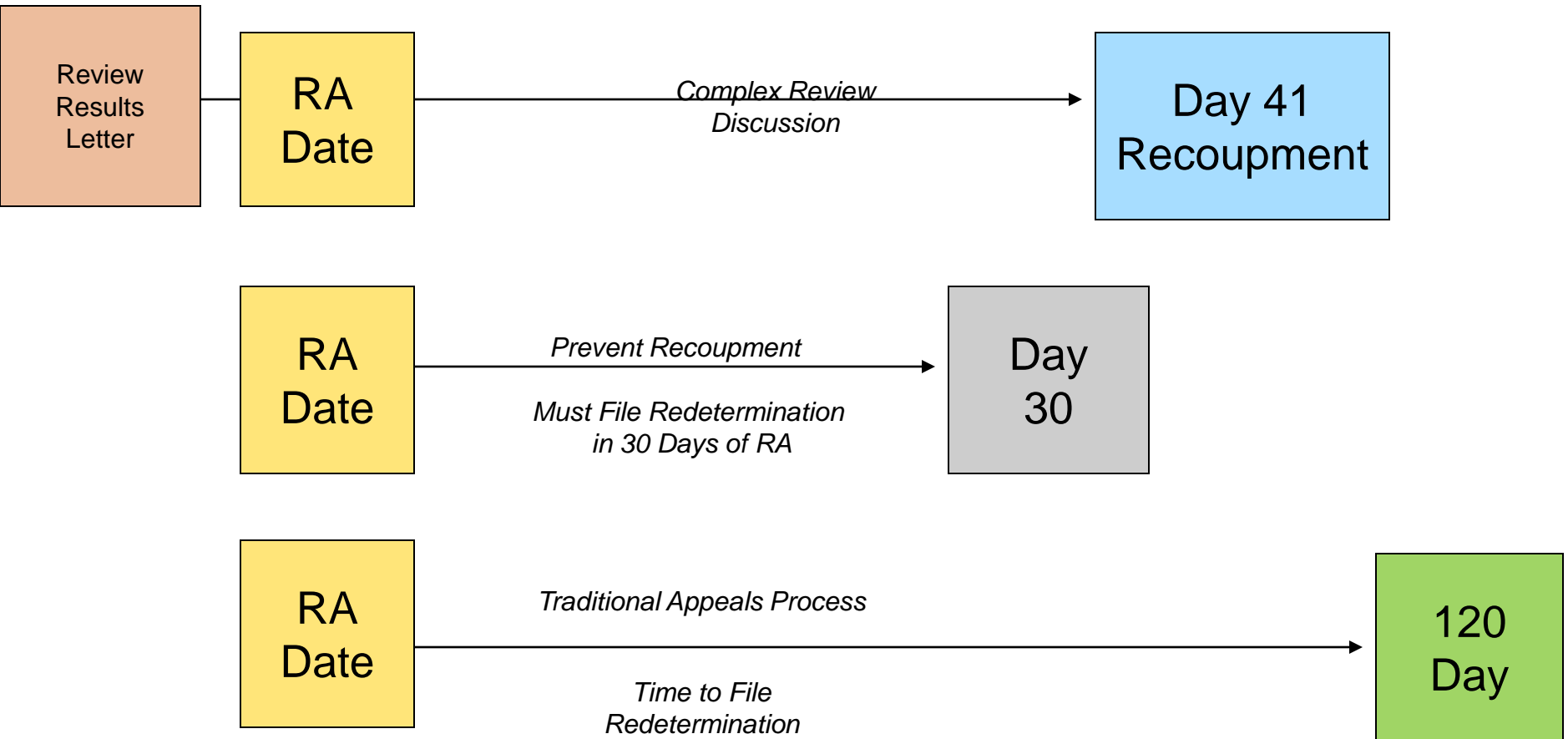
¹ Medicare assumes receipt 5 days from date of notice

² These amounts are adjusted based on the Medicare component of the CPI

Issue

- There Are At Least 3 Processes and Deadlines Involving RAC and MAC Appeals
- Providers Need To Be Aware of These
- Providers Need A Defined Strategy and Process for Responding Timely

Three Timelines



Timelines for RAC Review and Denials and Traditional Appeals Have To Be Carefully Managed

- Note the Remittance Advice Date
- Note the Demand Letter Date
- Read RAC Demand Letter Carefully
- Note the RAC Discussion Dates
- Preventing Recoupment and Strategy Must Be Considered In Terms of Effect on Timelines, Finances, Quality of Grounds for Appeals





Timelines for RAC Review and Denials and Traditional Appeals Have To Be Carefully Managed

- Therefore You Are Balancing Multiple Different Timelines
- Initial Determination Triggers Traditional Process for Appeals
- Definition of Initial Determination is Key

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.

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

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.



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



INPATIENT REHABILITATION FACILITIES PROSPECTIVE PAYMENT SYSTEM (IRF – PPS)



So You Want To Be Paid?



IRF-PPS Inclusions And Exclusions

- Includes:
 - PPS Excluded Rehab Hospitals and Units in US & Territories
 - Capital and Inpatient Operating Costs
- Excludes:
 - Hospitals and Units in Demo Programs (MD)
 - Costs of Bad Debt, Educational Programs, Blood Clotting Factor Units
 - Physician, PA, NP, Midwife, Qualified Psychologist & Anesthetists Services.

IRF-PPS

- Applies to Traditional FFS Medicare Only
- Physician Billing is Separate - Part B, PFS
- Incentive is to Have the Patient's Costs Stay Under the Payment.
 - Most Often Equated to Length of Stay Management
 - Bad, Bad, Bad Idea and CMS Agrees



IRF-PPS Basics

- Data Collection
 - Inpatient Rehabilitation Facility –Patient Assessment Instrument (IRF-PAI)
- Patient Classification System- Case Mix Groups (CMGs)
- Per Discharge Payment Adjusted For Facility Characteristics
- Special Payment Policies, Outlier Policy

FY 2006: First Refinements

- CMGs Now 92 Total CMGs
- Changed Comorbidities; Revised Tier Structure
- Moved to Weighted Motor FIM
- Added Teaching
- Adjusted Outlier Policy
- Took a 1.9 % Reduction for Coding
- Move To CBSAs

IRF-PPS Basics

- CMG Weights Reflect
 - Acuity of Patient (Comorbidity)
 - Function
 - Age
 - Condition
 - Resource Use (\$\$)
 - Are Relative
 - Norm of 1



IRF-PPS Basics

Facility Adjusters for FY 2011

- Wages – Increased Labor Share to 75.779
- Decreased Rural Adjustment – 18.4%
- LIP $((1 + \text{DSH})^{0.4613})$
- Teaching – $((1 + \text{FTE} / \text{ADC})^{0.6876*})$
- Unchanged from FY 2010



Special Payment Policies

- Majority of Cases – Patients Assigned CMG and Get One Payment
- Short Stay – Three Days or Less CMG 5001
- Death CMGs 5101 - 5104

Special Payment Policies

- Transfers
 - Sent to Other Medicare Providers
 - Formula (CMG Payment/ CMG ALOS) x LOS + 50 % of Per Diem
- Interrupted Stays
 - Patient Returns to Same Facility On Day of Discharge or By Midnight of Third Consecutive Day
 - Stated Very Curiously Re: Payment



Payment Formula

- $SA \times \text{Weight (Includes Comorbidity Tiers)} \times FA + \text{Outlier} = \text{Payment}$
- Standardized Amount FY 2010 = \$13,661

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	-.5830%
Final FY 2010	\$13,661	+5.43%
Adjusted FY 2010 per PPACA	\$13, 627	-0.25
FY 2011	\$13,860	+1.70%



Role of Medical Director/Rehab Physician

- Be Familiar with Rehab Impairment Categories and Impairment Group Codes
- Be Familiar with Comorbidity Tiers
 - A = None
 - D = Most Severe
 - Tier 1 = Most Severe
 - Tier 3 = Least Severe
- Be Familiar with ICD-9-CMs
- Provide Complete Verbal, Written, Dictated Description of Patient On Admission, in H+P and Post Admission Evaluation So Coders Can Properly Assign IGC, RIC, then CMG and Tiers

What's My CMG?



1. Look for the ICD-9-CM That Fits
2. Place in Impairment Group Codes (IGCs) to Determine Stroke, Amputation, Etc.
3. Figure Out RIC (21) from IGC
4. Look at Functional Scores, Age at Admission
5. Put All The Information on the IRF-PAI
6. Check the Comorbidities List for Tier CCs As Well As Others

Do You Know How To Code?



- IRF-PAI Coding
 - ICD-9-CM = ICG
 - Functional Motor + Cognitive Scores
 - Pay Attention to Dates for Recording & Submission
- Capture All Comorbidities
- Pay Attention to Discharge Dates for Transfer and Short Stay Cases
- Recheck Your FA Against What Your FI Gave You

Payment Example



- Medical Record Shows
 - CVA – Left Sided Hemi Paresis
 - Renal Dialysis, Prostate Cancer, Other Severe Malnutrition
 - Motor FIM 26
 - Age 75
- IRF-PAI Shows
 - Motor FIM 26



Payment Example

Unadjusted

- RIC = Stroke
- Scores = CMG 0109
- Comorbidities = V45.11 = Tier 1
- Unadjusted Payment = \$30,515.56 for FY 2011



CONTACT INFORMATION

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APPENDIX

Additional Resources

- Billing
 - Pub 100-4, Chapter 3, Section 140
- CMS IRF Home Page
 - <http://www.cms.hhs.gov/ImpatientRehabFacPPS/>
- CMG for FY 2011
 - FY 2011 IRF PPS Notice, July 22, 2010

Physician Documents The:



- Initial Assessment
 - Reason for Admission
 - Need for Rehab Level of Physician Services
 - Need for Intense Level of Therapy
- History
 - Prior Level of Function Plus Past Medical History
 - Previous Treatment for the Diagnosis, Impact of Treatment, How Effect Potential for Improvement
 - Date on Onset/Exacerbation
 - Living Situation

Physician Documents The:



- Exam
 - Describe Illness or Surgery Responsible for IRF Admission
 - Recent Losses in Functional Ability Such That The Patients Cannot Live Alone
 - Comorbid Conditions and Expected Impact/Risk They Pose To The Patient
 - Expected Improvement
- Post Admission Evaluation As Well!

Physician Documents The:



- Assessment and Plan
 - Short, Discharge, Long Term Goals
- Orders
 - Therapy
 - Identify Specific Therapies
 - Restriction/Precautions
 - Equipment



60% Rule

42 CFR 412.23 (b)(2)(ii)

- A. Stroke
- B. Spinal Cord Injury
- C. Congenital Deformity
- D. Amputation
- E. Major Multiple Trauma
- F. Fracture of Femur
(Hip Fracture)
- G. Brain Injury
- H. Neurological Disorders (including MS, motor neuron disease, polyneuropathy, muscular dystrophy; and Parkinson's disease)
- I. Burns

60% Rule

- J. Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

60% Rule

K. Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

60% Rule

- L. Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission....

60% Rule

- L.but have the potential to improve with more intensive rehabilitation. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)

60% Rule

M. Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meet one or more of the following specific criteria:

- (1) The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.
- (2) The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.
- (3) The patient is age 85 or older at the time of admission to the IRF.

Comorbidities

42 CFR 412.23 (b)(2)(i)(A-C)

- A patient with a comorbidity, as defined at Sec. 412.602, may be included in the inpatient population that counts towards the required applicable percentage if –
 - (A) The patient is admitted for inpatient rehabilitation for a condition that is not one of the conditions specified in paragraph (b)(2)(iii) of this section;
 - (B) The patient has a comorbidity that falls in one of the conditions specified in paragraph (b)(2)(iii) of this section; and

Comorbidities

42 CFR 412.23 (b)(2)(i)(A-C)

- (C) The comorbidity has
- i. caused significant decline in functional ability in the individual such that, even in the absence of the admitting condition,
 - ii. the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid under subpart P of this part and
 - iii. that cannot be appropriately performed in another care setting covered under this title.

Comorbidities

42 CFR 412.23 (b)(2)(i)(A-C)

- A Comorbidity is Defined as:

“a specific condition that is secondary to the patient’s principal diagnosis that is the primary reason for the inpatient rehabilitation stay.”

42 CFR 412.602



History of CMS Actions on the 60% Rule

- Final Rule, January 1984
- 1990s Efforts to Expand “HCFA 10”
- Provider Call, February 2002
- AMRPA Meets With CMS, February 2002
- Survey of FI Enforcement Activity, Spring 2002
- Moratorium of Enforcement, June 7 2002
- FY 2004 Rate Increase and Notice of Proposed Rulemaking (NPRM), May 16, 2003
- RAND Report, May 16, 2003



History of CMS Actions on the 60% Rule

- RAND Report, May 16, 2003
- NPRM, September 9, 2003
- Final Rule, May 7, 2004
- Transmittal 221, June 25, 2004
- Transmittal 347, October 29, 2004
- Transmittal 97, January 21, 2005
- Fact Sheet #1, January 21, 2005



History of CMS Actions...

- Memo to ROs and FIs, January 29, 2005
- MedLearn Article, January, 2005
- Fact Sheet #2, February 16, 2005
- Provider Calls February 23 and March 23, 2005
- Transmittal 478, February 22, 2005
- Issued Transcript of Provider Education Calls, September 16, 2005



History of CMS Actions...

- Transmittal 938, May 5, 2006
- Compliance Workbook A + B for FIs, May 2006
- MedLearn Matters Article MM5016
- CSR Inquiry Assistance re: MM5016
- CMS Releases CASPER Specification;
Specification For Determining IRF “75 % Rule”
Compliance (CASPER) – September 26, 2006



History of CMS Actions...

- Transmittal 1135 (CR 5303) IRF Compliance Percentage Threshold, 12/06
- IRF – PPS Fact Sheet, March 2007 (Covers Exclusion Criteria)
- Request for Comments on Comorbidity Policy in FY 2008 Proposed Rule, May 8, 2007
- CMS Report to Congress on the 75 Percent Rule, June 8, 2007



History of CMS Actions...

- CMS Releases Second Edition of CASPER Specifications, October 1, 2007
- April 29, 2008 IRF- PPS NPRM for FY 2009
- August 8, 2008 FY 2009 IRF- PPS Final Rule
- August 7, 2009 FY 2010 IRF PPS Final Rule
- July 22, 2010 FY 2011 IRF PPS Notice





Rehabilitation Units – Common Requirements

42 CFR 412.25(a)

- Has Admission and Discharge Records That Are Separately Identified From Those of the Hospital in Which It Is Located and Are Readily Available
- Has Policies Specifying That Necessary Clinical Information Is Transferred To The Unit When A Patient Of The Hospital Is Transferred To The Unit
- Meets Applicable State Licensure Laws



Rehabilitation Units – Common Requirements

42 CFR 412.25(a)

- Has Utilization Review Standards Applicable for the Type of Care Offered In The Unit.
- Has Beds Physically Separate from (That Is, Not Commingled With) The Hospital's Other Beds.
- Is Serviced By The Same Fiscal Intermediary As The Hospital.



Rehabilitation Units – Common Requirements

42 CFR 412.25(a)

- Is Treated As A Separate Cost Center For Cost Finding And Appointment Purposes
- Uses An Accounting System That Properly Allocates Costs
- Maintains Adequate Statistical Data To Support The Basis Of Allocation



Rehabilitation Units – Common Requirements

42 CFR 412.25(a)

- Reports Costs In The Hospital's Cost Report Covering The Same Fiscal Period And Using The Same Apportionment Method As The Hospital
- On The First Day Of The First CRP For Which All Other Exclusion Requirements Are Met, The Unit Is Fully Equipped And Staffed And Is Capable Of Providing Hospital Rehab Care Whether There Are Any Unit Inpatients on That Date



Specific Criteria for Rehab Units

42 CFR 412.29(a)

- Meet the Requirements For A New Unit Under 412.30(a)

OR

- Meet the Requirements For Converted Units Under 412.30(c)



Specific Criteria for Rehab Units

42 CFR 412.29(b-e)

Before and After 1/1/10

- Same As a Rehab Hospital Regarding Preadmission Screening, Medical Supervision and Personnel, Plan of Treatment, Multidisciplinary Team, and 60% Rule
- Conformed with changes to criteria for rehab hospitals effective for discharges on or after 1/1/10



Specific Criteria for Rehab Units

42 CFR 412.29(f)

- Has A Director Of Rehabilitation Who
 - Provides Services To The Unit And To Its Inpatients For At Least 20 Hours Per Week;
 - All Other Medical Director Requirements Are The Same as Those for the Rehabilitation Hospital



Changes In Size of Excluded Units

42 CFR 412.25(b)

- Increase Number of Beds and Square Footage Only At Start of CRP
- Decrease In Number of Beds and Square Footage Any Time During CRP
 - 30 Days Notice To FI
 - Any Decrease in Number of Beds or Square Footage Must Remain in Effect Through Balance of CRP
- Exception Allowed to Relocate the Unit to Permit Construction Due to Legal Requirements Or Natural Disasters



Changes in Status of Units *42CFR 412.25(c)-(d),(f)*

- Not Excluded to Excluded
 - Only At Start of CRP
- Excluded to Not Excluded
 - At Any Time
 - 30 Days Notice to FI
- Only 1 of Each Unit
- No Change in Classification Except at Start of CRP
- Satellite Facilities in Appendix

Decrease in Beds (Units)

42 CFR 412.30(a)

- Decrease Remains in Effect for One Full 12 Month CRP Before Equal or Lesser Number of Beds Can Be Added to Hospital License and Certification and Considered New
- RO will Review its Records Regarding 12 Months CRP Prior to CRP for Which It Seeks to Add Beds
- If Beds Removed During That CRP, Beds May Not Be Considered New

New Units

42 CFR 412.30(b)

1. A Unit Is Considered New Unit If The Hospital—
 - (i) Has Not Previously Sought Exclusion For A Rehabilitation Unit; And (ii) Has Obtained Approval, Under State Licensure And Medicare Certification, For An Increase In Its Hospital Bed Capacity That Is Greater Than 50 Percent Of The Number Of Beds In The Unit
2. It May Attest That It Will Meet The 60% Rule

New Units

42 CFR 412.30(b)

3. The Attestation Is Effective For The First Full CRP During Which The Unit Provides Care
4. If A Hospital That Has Not Previously Participated In Medicare Seeks Exclusion Of A Unit, It May Designate Certain Beds As A New Unit For The First Full 12-month CRP That Occurs After It Becomes A Medicare- Participating Hospital. The Attestation Is Effective For Any CRP Of Not Less Than 1 Month And Not More Than 11Months Occurring Between The Date The Hospital Began Participating And The Start Of The Hospital's Regular 12-month CRP

New Units

42 CFR 412.30(b) Cont.

5. A Hospital That Has Undergone A Change Of Ownership Or Leasing As Defined In Sec. 489.18 Is Not Considered To Have Participated Previously In Medicare

Converted Units

42 CFR 412.30(c)

- A Hospital Unit Is Considered A Converted Unit If It Does Not Qualify As A New Unit. A Converted Unit Must Have Treated, For The Most Recent Consecutive and Appropriate 12-month Period, An Inpatient Population That Meets The 60% Rule.

Expansion of Excluded Units

42 CFR 412.30(d)(1)

- New Bed Capacity - Additional Beds Are Considered New Beds Only If–
 - (i) The Hospital's State-Licensed And Medicare-Certified Bed Capacity Increases At The Start Of The CRP For Which It Seeks To Increase The Size Of The Unit, Or At Any Time After The Start Of The Preceding CRP; And
 - (ii) The Hospital Has Obtained Approval, Under State Licensure And Medicare Certification, For An Increase In Its Hospital Bed Capacity That Is Greater Than 50 Percent Of The Number Of Beds It Seeks To Add.



Conversion Of Bed Capacity

42 CFR 412.30(d)(2)

Conversion Of Existing Bed Capacity

- (i) Beds Are Considered To Be Existing Beds If They Do Not Meet The Definition Of New Beds
- (ii) A Hospital May Increase The Size Of Its Unit By Converting Existing Beds Only If It Shows That, For All Of The Hospital's Most Recent, Consecutive Appropriate 12 Month Period Of At Least 12 Months, The Beds Have Been Used To Treat An Inpatient Population That Meets The 60% Rule

Pre Jan. 1, 2010 Criteria



To Be Covered (HCFA 85-2)

- The Services Must Be Reasonable and Necessary (In Terms of Efficacy, Duration, Frequency, and Amount) for the Treatment of The Patient's Condition;
- and
- It Must Be Reasonable and Necessary to Furnish the Care on an Inpatient Hospital Basis, Rather Than in a Less Intensive Facility, Such As a SNF, or On an Outpatient Basis

Coverage Criteria HCFA 85-2

- Reasonable and Necessary Satisfied in 2 Ways
 - Meet Eight (8) Criteria For Rehabilitation Inpatient Hospital Stay; Or
 - If The Stay Can Be Justified on “Medical or Surgical Grounds”
- CMS MBPM Says” the patient requires a rehabilitative hospital level of care if all of the...screening criteria are met.”



Coverage: First Issue

- Rules of Thumb, Numerical Utilization Screens or Diagnostic Screens Cannot Be Used.
- Statement Regarding SNF May Be an Example and May Also Include Home Health.



Coverage

Hallmarks Of Rehabilitation

(HCFA 85-2)

- A. General
- B. Preadmission Screening – Encouraged, Not Mandatory
- C. Inpatient Assessment of an Individual's Status and Potential for Rehabilitation
 - Assessment May Take 3-10 Days
 - Will Cover Even When Deemed Not To Be a Candidate
 - Is 3-10 Days Still Happening When Average LOS is 13 Days?

Coverage Hallmarks Cont.

- D. Inpatient Rehabilitation Care [Referred To In MBPM as Rehabilitation Hospital Screening Criteria]
1. Close Medical Supervision by Physician with Specialized Training or Experience in Rehabilitation
 2. 24 Hour Rehabilitation Nursing
 3. Relatively Intense Rehabilitation Services
 - “3 Hour Rule”
 - Specific Examples

Hallmarks Cont'd

4. Multidisciplinary Team
5. Coordinated Program of Care;
6. Significant Practical – “Reasonable Period of Time” Improvement;
7. Realistic Goals; and

Hallmarks Cont'd

8. Length of Rehabilitation Program

- Coverage stops when further progress toward goal is unlikely or can be achieved in less intense setting
- When discharge is appropriate, the cutoff point for coverage is when “it would have been reasonable for the physician to conclude that further improvement would not occur...” [emphasis added] (Sec. 110.5)