CMS Update: New Initiatives, Final Rule, Coverage Criteria, & PEPPER Reports

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Agenda

- Health Care Reform
- FY 2012 IRF PPS Final Rule
  - Payment Rate Update
  - Quality Reporting
- PEPPER Reports—Overview
- IRF Coverage Criteria
- Questions and Answers

Health Care Reform

Medicare Reimbursement Provisions

Health care reform: Medicare reimbursement for IRFs

- **Productivity Adjustments**: For FY2012 and thereafter, the increase factor will be reduced by a productivity adjustment. PPACA, §3401(d)(1)

- **Annual Update Adjustments**: Beginning in FY2010 and through FY2019, the increase factor will also be reduced by an "other adjustment" – 0.25% in FYs 2010 and 2011, 0.1% in FYs 2012 and 2013, 0.3% in FY2014, 0.2% in FYs 2015 and 2016, and 0.75% in FYs 2017-2019. PPACA, §§3401(d)(2), 10319(c); HCERA, §1105(c)

- **Combined Effect**: These adjustments may result in payment rates for a FY being less than such rates for the prior FY. PPACA, §3401(d)(1)

Other provisions affecting Medicare reimbursement: Bundling

- Post-Acute Care Payment Bundling (PPACA, §§3023 and 10308)
  - No later than January 1, 2013, Secretary to establish 5-year pilot program covering hospitals, physicians, SNFs, and home health
  - May include bundled payments and episode of care bids
  - "Continuing care hospital" model to be separately tested as part of the pilot

Other provisions affecting Medicare reimbursement: Shared savings program

- Medicare Shared Savings Program (PPACA, §3022)
  - Groups of providers and suppliers may work together to manage and coordinate care for Medicare fee for service beneficiaries through accountable care organizations (ACOs)
  - ACOs to receive payments for shared savings if quality performance standards met.

FY 2012 Final Rule

Payment Rate Updates

Payment Rate Updates

- **Market Basket Increase Factor**: We estimate the market basket increase factor for FY 2012 to be 1.8 percent. This estimate is based on a 2008-based RPL market basket increase factor of 2.9, reduced by 0.1 percentage point and by a 1.0 productivity adjustment as mandated by the Affordable Care Act.

- **Facility-Level Adjustments**: We froze the adjustments at FY 2011 levels to analyze the underlying data and approaches that would improve the accuracy of the adjustments.

Facility-Level Adjustments

We are working with MedPAC and others to:

- Investigate some of the large variations in cost structures that exist among different types of facilities in the IRF data.

- Analyze and, if necessary, refine the methodologies that we use to set the facility-level adjustments to make sure that our estimates reflect as accurately as possible differences in cost structures among different types of IRFs.

Payment Rate Update cont'd

Payment Rate Updates	FY 2011 Values	FY 2012 Final Values
RPL Market Basket	2.5%	2.9%
Productivity Adjustment	N/A	(1.0%)
Affordable Care Act Mandated Reduction	(0.25%)	(0.1%)
Total Increase Factor	**2.25%**	**1.8%**
RPL Labor Related Share	75.271%	70.199%
Standard Payment Conversion Factor	$13,860	$14,076

The final changes result in an estimated increase in IRF payments of $150 million for FY 2012, reflecting a $120 million increase from the market basket increase factor and a $30 million increase due to the update to the outlier threshold amount.

Updates to the Payment Regulations

- Consolidate requirements into one section (§ 412.29) for both freestanding IRF hospitals and IRF units of acute care hospitals
- Eliminate out-dated rules regarding "new" and "converted" IRFs
- Allow IRFs to add new beds at any time (one time) during a cost reporting period
- Articulate new rules regarding changes of ownership and mergers

Policy for Temporary Cap Adjustments

- We implemented policies for temporary cap adjustments due to hospital or residency program closures, consistent with the IPPS GME/IME policy and Inpatient Psychiatric Facility PPS policies.

- Specifically, we allow temporary intern and resident cap increases in the following two circumstances:

  - Closure of an IRF (IRF terminates the Medicare provider agreement)

  - Closure of Teaching Program (IRF ceases to offer training for all residents in a particular approved medical residency training program)

Quality Reporting

- IRF Quality Reporting Program to be implemented in accordance with section 3004 of the Affordable Care Act

- CMS will begin collecting quality data from IRFs for the first year of the program from October 1, 2012 to December 31, 2012

- The initial quality measures:
  - Urinary Catheter-Associated Urinary Tract Infections
  - Pressure Ulcers that are New or Have Worsened

- Other new measures for reporting will be added through future rulemaking

IRF PEPPER Reports

- Provide hospital-specific comparative data in areas identified as potentially at risk for improper Medicare payments.

- Identify when a provider is at/above the national 80th percentile for a target area during a specified time period.

- Intended as a tool to support internal compliance/auditing/monitoring efforts to help IRFs identify and prevent improper Medicare payments.

IRFs are not required to take any action.

IRF PEPPER Report Target Areas

TARGET AREA	TARGET AREA DEFINITION
Miscellaneous CMGs (Misc)	*Numerator (N):* count of discharges for Case-Mix Groups (CMGs) 2001 (Miscellaneous M>49.15), 2002 (Miscellaneous M>38.75 and M<49.15), 2003 (Miscellaneous M>27.85 and M<38.75) or 2004 (Miscellaneous M<27.85) *Denominator (D):* count of all discharges
CMGs at Risk for Unnecessary Admissions (CMGs)	*N:* count of discharges with no tier group assignment for CMGs 0101 (Stroke M>51.05), 0501 (Non-traumatic Spinal Cord Injury M>51.35), 0601 (Neurological M>47.75), 0801 (Replacement of Lower Extremity Joint M>49.55), 0802 (Replacement of Lower Extremity Joint M>37.05 and M<49.55), 0901 (Other Orthopedic M>44.75), 1401 (Cardiac M>48.85), or 1501 (Pulmonary M>49.25) *D:* count of all discharges
Outlier Payments (Outlier Pmts)	*N:* count of discharges with an outlier approved amount greater than $0 *D:* count of all discharges
STACH Admissions Following IRF Discharge (STACH Admiss)	*N*: count of beneficiaries (identified using the Health Insurance Claim number) discharged from the IRF during the 12-month time period that were admitted to a short-term acute care hospital within 30 days of discharge from the IRF; patient discharge status code of the index (IRF) admission is not equal to 02 (discharged/transferred to a short-term acute care hospital) *D*: count of all discharges excluding patient discharge status code 20 (expired)

IRF PEPPER Report Outreach

For more information, please refer to:

www.PEPPERresources.org

- Contains a Help Desk for questions about the PEPPERs
- A recording of the September 23 web-based training session is available for download on the website

Coverage Criteria

Documentation in the IRF patient's medical record must:

- Support medical necessity
- Be complete and legible
- Not be presented as check-off lists

Quiz

True or False:

Medicare is looking to deny a claim based on a technicality.

FALSE

Coverage Criteria

The intent of the coverage criteria is to:

- Ensure that quality care is being provided to patients
- Assist providers in knowing what CMS expects to see in the medical record, so there are no surprises when a claim is reviewed

Coverage Criteria

Preadmission Screening—Basics

- The physician must review, sign and date the preadmission screening before the patient is admitted to the IRF
- The preadmission screening must include the specific reasons that led the IRF clinical staff to conclude the admission was reasonable and necessary
- The preadmission screening must demonstrate that each individual patient for IRF admission was assessed for medical and functional appropriateness. **Check-off boxes do not adequately demonstrate that an individualized assessment took place.**

Quiz

True or False:

An email (with no attachment) dated prior to the IRF admission that states that the rehabilitation physician "Agrees with the admission decision" is sufficient to document the rehabilitation physician's review and concurrence with the preadmission screening.

FALSE

Quiz

True or False:

As long as all of the correct boxes are checked on the preadmission screening form indicating that the patient meets all of the Medicare coverage requirements, Medicare contractors will consider the IRF admission reasonable and necessary.

FALSE

Good Example

Patient A requires, can tolerate, and can reasonably be expected to benefit from 3 hours of therapy per day/5 days per week.

Yes, this patient is expected to meet this requirement because he/she has cerebral artery occlusion with comorbidities of pneumonia, dysarthria, and ataxia . He/she is able to ambulate 100 feet with mod assist, and we expect that with an intensive course of therapy will improve to the point that he/she can return home with a walker within 3 weeks.

Bad Example

Patient A requires, can tolerate, and can reasonably be expected to benefit from 3 hours of therapy per day/5 days per week.

Yes___X___ No________

Quiz

True or False:

The information presented in the preadmission screening must be consistent with the other information provided in the patient's medical record, or a plausible explanation be given for why they differ, in order for the preadmission screening to support the IRF admission.

TRUE

Coverage Criteria

Post-Admission Physician Evaluation

- Must be performed by the rehabilitation physician within 24 hours of the patient's admission to the IRF, though physician extenders may assist in completing the patient's history and physical
- The documentation in the post-admission physician evaluation must support the medical necessity of the admission
- Must be consistent with other medical/functional information and findings in the medical record

Quiz

True or False:

To meet the post-admission physician evaluation requirement, a rehabilitation physician may sign-off on an evaluation that was performed by a trusted physician assistant.

FALSE

Coverage Criteria

Minimum 3 Rehabilitation Physician Visits Per Week

- Must be comprehensive
- Must assess the patient's status both medically and functionally
- Must be performed by a rehabilitation physician

Quiz

True or False:

To meet the physician visit requirement, a rehabilitation physician can simply document that the patient's vital signs and blood pressure are stable and that the patient can continue the prescribed course of therapy.

FALSE

Quiz

True or False:

To meet the physician visit requirement, documentation may simply show that a comprehensive assessment of the patient's medical and functional status led the rehabilitation physician to conclude that the patient was progressing nicely and should therefore continue with the prescribed course of therapy.

TRUE

Quiz

True or False:

The post-admission physician evaluation may serve as one of the three required rehabilitation physician visits in the first week.

FALSE

Coverage Criteria

Interdisciplinary Team Conferences

- Must be led by a rehabilitation physician
- Must be held at least once per week
- Must assess the patient's status both medically and functionally
- Must discuss the patient's progress toward goal attainment and any relevant barriers to the patient's attainment of goals

Quiz

True or False:

Group therapy may count towards the intensive rehabilitation therapy requirement if the patient's benefit from this type of therapy is well-documented in the patient's medical record and it is not provided merely for the convenience of the staff.

TRUE

Quiz

True or False:

– This presentation has gone on long enough.

Almost—but not quite!

QUESTIONS AND ANSWERS