

The 50 Percent Solution: Is CMS' "Final" Revision to the 75 Percent Rule Final?

by

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Introduction

When CMS issued its proposed revision to the "75 percent rule" for qualifying an inpatient rehabilitation facility ("IRF") for Medicare certification in September 2003, it issued a challenge to the rehabilitation provider community. Basically the challenge stated that, if providers wished to have single-joint hip and knee replacements counted as a qualifying condition for IRF certification, they should furnish CMS with data justifying the benefit of treating joint replacement patients in an IRF setting as opposed to outpatient rehabilitation. However, instead of accepting CMS' challenge, the providers turned to their Congressional representatives and senators. As we shall see, despite CMS' issuance of a "final" rule on May 7, 2004,¹ it appears that Congress will indeed have the final say on the ultimate disposition of the 75 percent rule.

The Current 75 Percent Rule

As we have previously discussed,² the 75 percent rule is a methodology adopted by CMS for the purpose of establishing that an IRF³ is, indeed, primarily engaged in providing intensive rehabilitation services as opposed to general medical and surgical services with some rehabilitation services.

The current 75 percent rule requires that, for the hospital's most recent 12-month cost reporting period, at least 75 percent of the IRF's patients required treatment for one of 10 specified conditions:

- Stroke;
- Spinal cord injury;
- Congenital deformity;
- Amputation;
- Major multiple trauma;
- Hip fracture;
- Brain injury;
- Polyarthritis including rheumatoid arthritis;

¹ 60 Fed. Reg. 25752 (May 7, 2004).

² Cheryl G. Murer, JD, CRA, "The 65/75 Split," Rehab Management (November 2003).

³ IRFs encompass both rehabilitation hospitals and distinct part rehabilitation units of hospitals.

- Neurological disorders, including multiple sclerosis, motor neuron diseases, Polyneuropathy, muscular dystrophy, and Parkinson's disease; and
- Burns.

The 75 percent rule has remained virtually unchanged for 20 years.⁴

Non-compliance and moratorium

A firestorm of controversy erupted in early 2002, when several inpatient rehabilitation facilities in New Jersey and Tennessee were issued notices of non-compliance by their fiscal intermediaries after audits of their admission diagnosis categories. In July 2002, CMS suspended enforcement of the 75 percent rule. The moratorium on enforcement, which has remained in effect since that date, is scheduled to expire when the revised 75 percent rule takes effect on July 1, 2004.

The Revised Rule: More Apparently Is Not Enough

When CMS proposed the revision to the 75 percent rule on September 9, 2003,⁵ it declined to follow the suggestion put forth by many providers that it replace the 10 qualifying conditions with 20 of the 21 Rehabilitation Impairment Categories ("RICs") that are used in formulating payments under the Rehabilitation Prospective Payment System. In the final rule, CMS continues to assert that the RICs are not an appropriate basis for determining IRF qualification. However, CMS has agreed to allow providers more flexibility in achieving compliance,

The final rule's most important feature is that, for its first year in effect, it reduces from 75 to 50 the percentage of patients in the facility who are admitted because they are diagnosed with one of the specific qualifying medical conditions and require intensive inpatient rehabilitation services. After the first year, the rule gradually brings the qualifying percentage back to 75 percent in 2007. This is both more lenient and more flexible than the proposed rule, which would have reduced the initial compliance percentage only to 65 percent, before returning to 75 percent. In detail, the rule, unless rescinded, will operate as follows:

1. 50 percent for cost reporting periods beginning on or after July 1, 2004 and before July 1, 2005;
2. 60 percent for cost reporting periods beginning on or after July 1, 2005 and before July 1, 2006;
3. 65 percent for cost reporting periods beginning on or after July 1, 2006 and before July 1, 2007; and
4. 75 percent for cost reporting periods beginning on or after July 1, 2007.

⁴ The current 75 percent rule is codified at 42 C.F.R. § 412.23(b)(2).

⁵ 68 Fed. Reg. 53266 (September 9, 2003). CMS will accept comments on the proposed rule until November 3, 2003, and expects the final rule to take effect on January 1, 2004.

The final rule retains other important aspects of the proposed rule, including:

- Deleting the term “polyarthritis” from the current list of 10 qualifying conditions and replacing it with three groups of conditions that will more precisely identify the types of arthritis related conditions appropriate for care in a rehabilitation facility. As a result there will be 12 qualifying conditions.
- Continuing to use the facility’s total patient population to determine compliance with the applicable percentage. However, the rule establishes an administrative presumption that if the facility’s Medicare patient population complies with the rule, the facility’s total population complies.
- Secondary medical conditions that meet one of the 12 proposed conditions will be counted toward the applicable percentage.
- The compliance percentage returns to 75 with cost reporting periods beginning on or after July 1, 2007, and the use of a secondary medical condition to determine compliance will no longer be allowed as of that date.

The final rule retains the 10 qualifying conditions specified in the existing rule, but replaces polyarthritis with three new, more specific conditions: active polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies; systematic vasculidities with joint inflammation; and severe or advanced osteoarthritis involving two or more major weight bearing joints (as opposed to three or more major joints in the proposed rule). None of these three new conditions will qualify as compliant unless they also involve significant functional impairment that has not responded to an aggressive, sustained course of outpatient treatment.

During the 3-year period after the new rule goes into effect, CMS plans to closely review both claims and patient assessment data to examine trends in admissions and overall IRF utilization to assess the effectiveness of the new rule. CMS believes that this assessment, together with the increased flexibility allowed by the rule and any further adjustments to be proposed as a result of the assessment, will answer providers’ complaints that the rule does not take into account developments in clinical medicine that have changed the basic mix of patients who may benefit from intensive rehabilitation services.

The Battle over Knees and Hips

As we noted in our previous article, CMS took the position in the proposed rule that IRF treatment is not medically justified for typical single-joint hip and knee replacements. While challenging providers to present clinical study data demonstrating better outcomes for hip and knee patients in inpatient settings as opposed to outpatient, CMS did propose an alternative qualifying methodology

for hip and knee patients, whereby such patients would qualify if they had significant comorbidities that fell within one or more of the 12 qualifying conditions, the comorbidity resulted in significant functional impairment, and an IRF was the only effective venue for treating the condition.

This proposal was clearly inadequate for the provider community, which quickly found a sympathetic ear in Congress. The House and Senate Conference Committees for the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,⁶ and the Consolidated Appropriations Act of 2003,⁷ added non-binding language to these bills that called on CMS to withhold implementing the proposed rule pending the results of a study by the Institute of Medicine as to which medical conditions are clinically appropriate for inclusion in the rule. The committee for the Consolidated Appropriations Act further advised CMS to order the fiscal intermediaries not to implement any local medical review policies (LMRPs) based on the rule.

Instead of responding to these requests, CMS has placed in the final rule a provision for hip and knee replacements that is somewhat more lenient than the proposed rule, but by no means as open as that which the provider community has been seeking. The final rule counts hip or knee replacements as qualifying conditions if one of the following three conditions is satisfied:

1. The patient underwent a bilateral hip or knee replacement during an inpatient hospital stay 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; or
3. The patient is age 85 or older at the time of admission to the IRF.

Curiously CMS did not explain why it had decided to implement the final rule despite Congress' entreaties, nor did the commentary to the final rule make any mention of the requested Institute of Medicine study or the LMRPs.

Not surprisingly, the provider community was distinctly unsatisfied with the final rule and turned once again to Congress. No fewer than 82 senators signed a letter to Health and Human Services Secretary Tommy Thompson, dated June 17, 2004, expressing their disappointment with the final rule and calling upon CMS to delay implementation of the final rule pending the Institute of Medicine study, maintain the moratorium on enforcement of the present rule, and instruct the fiscal intermediaries not to implement any LMRPs based on the rule.

Conclusion

At this writing it is too soon to know what CMS' response to the senators' letter will be. Given the strength of Congressional opposition, it is safe to say that, if

⁶ P.L. 108-173.

⁷ P.L. 108-199.

CMS decides to go ahead with implementation of the final rule as it stands, binding Congressional action will not be long in coming. Whether this ultimately will mean replacement of the traditional qualifying conditions with a system based on the RICs remains to be seen. It is clear, however, that, unless CMS is willing to fundamentally alter its position, the last word on the 75 percent rule will be written in the halls of Congress and not CMS.

About the Author:

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