

The 65/75 Split: CMS Proposes Changes to the 75 Percent Rule

by

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Introduction

No governmental requirement related to the furnishing of inpatient rehabilitation services has generated more controversy than the criteria for being classified as an inpatient rehabilitation facility—the so-called “75 percent rule.” So heated has the controversy become that, for more than a year, CMS has suspended all enforcement of the rule. Now CMS has proposed changes to the 75 percent rule that it expects to begin enforcing in January, 2004. As we shall see, while these proposed changes will make it easier for providers to comply with the rule, they will not sweep in a host of new patients—specifically hip and knee replacement patients—that have not been allowed under the current rule.

History of the 75 Percent Rule

When Medicare first implemented the prospective payment system for acute care hospitals (“Acute PPS”) in 1983, it included in the new regulations a set of rules by which an inpatient rehabilitation facility (“IRF”)¹ could exclude itself from the Acute PPS. These rules included the original version of what has come to be known as the “75 percent rule.” The 75 percent rule was a methodology adopted by CMS for the purpose of establishing that the IRF was, indeed, primarily engaged in providing intensive rehabilitation services as opposed to general medical and surgical services with some rehabilitation services.

The original 75 percent rule required 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 eight specified conditions:

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

The following year two more qualifying conditions were added to the rule:

¹ The term “inpatient rehabilitation facility” encompasses 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.

With these two conditions added, the 75 percent rule has remained virtually unchanged for 20 years.² In fact, when CMS published the final rule implementing the prospective payment system for IRFs in August, 2001, it specifically declined to adopt the suggestions of several commentators that the 10 qualifying conditions be updated or that the rule be eliminated in its entirety.³

The Compliance Controversy

The appeals for change in the 2001 rule were but a foretaste of the controversy to come. The issue came to a head early in 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. Shortly thereafter, in a joint open letter to Tommy Thompson, the Secretary of the Department of Human Services, the American Medical Rehabilitation Providers Association, the American Academy of Neurology, the American Academy of Physical Medicine and Rehabilitation (AAPM&R), the American Hospital Association, and the Federation of American Hospitals, pointed out that data collected by CMS's IRF PPS contractor indicate that only 50 percent of the patients presenting at inpatient rehabilitation facilities were treated for a condition that fell into one or more of the ten categories.

The organizations who wrote the open letter to Secretary Thompson suggested that CMS adopt an administrative presumption whereby, if 75 percent of the hospital's or unit's Medicare patients fall in 20 of the 21 Rehabilitation Impairment Categories (RIC) used to classify patients into a Case-Mix Group (CMG) for the IRF PPS, then the facility would be presumed to comply with the 75 percent rule. Adoption of the RICs would have been particularly beneficial to facilities with a large percentage of hip and knee replacement patients, since joint replacement is one of the 20 categories. The organizations also urged that CMS place a moratorium on qualifying 75 percent rule audits by the fiscal intermediaries.

CMS responded to the providers' concerns in July 2002, by announcing that it was suspending enforcement of the 75 percent rule until it had completed a comprehensive study of the rule's relevance as it related to today's rehabilitation environment. Any feeling of vindication on the providers' part, however, was short lived, as CMS in May 2003 announced in a proposed rule that it was preparing to resume enforcement of the rule as it currently exists. However, in

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

³ 66 Fed. Reg. 41316, 41321 (August 7, 2001).

response to even more numerous complaints and comments from the rehabilitation community, when CMS issued the final update to the IRF PPS on August 1, 2003,⁴ it announced that it was revisiting the 75 percent rule and would, “in the very near future, issue a proposed rule that will contain a full discussion of our proposed changes of the existing 75 percent rule.” In the interim, CMS announced that the moratorium on enforcement of the 75 percent rule will be extended until a new rule is put into effect.

The Proposed Rule: More Flexibility for Providers, But Not an Open Door

While the rule that was proposed by CMS on September 9, 2003,⁵ certainly will allow providers more flexibility in achieving compliance, it is nowhere near the wholesale adoption of the RICs that the provider organizations were advocating. The proposed rule’s most important feature is that it would reduce from 75 to 65 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. Other highlights of the proposed rule include:

- 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 would be 12 qualifying conditions.
- Continue to use the facility’s total patient population to determine compliance with the proposed 65 percent rule. However, the proposed rule will establish 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 proposed 65 percent.
- The proposed rule will increase the compliance percentage back to 75 no later than three years from the effective date of the final rule and will phase out the use of the second medical condition to determine compliance.

The new rule would retain the 10 qualifying conditions specified in the existing rule, but would replace 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 three or more major joints. None of these three new conditions would qualify as compliant unless they also involved significant

⁴ 68 Fed. Reg. 45674 (August 1, 2003).

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.

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 rules. CMS believes that this assessment, together with the increased flexibility allowed by the proposal 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.

Little Relief for Knees and Hips

Although provisions of the proposed rule would appear to allow rehabilitation providers some additional flexibility in complying with rule, the new rule will not bring the majority of knee and hip replacements within the required 65 percent compliant group. Instead of opening up inpatient rehabilitation to knee and hip replacement patients, CMS has made it very clear that it does not consider an IRF to be the appropriate rehabilitation venue for the typical knee or hip patient. Instead, for hip and knee replacements, CMS is proposing an alternative methodology whereby such patients will be considered compliant only if, *at the time of admission to the rehabilitation facility*, the patient has *all* of the following:

- A condition that is complicated by an active comorbidity that falls within one of the 12 qualifying conditions;
- An active comorbidity that resulted in a decline in the patient's function beyond the decline generally observed for other patients in that impairment category; and
- An active comorbidity that substantially complicates the patient's rehabilitation to the point that it would improve only with the intensive, multidisciplinary rehabilitation treatment that is unique to an inpatient rehabilitation facility and could not be performed in another setting, such as a skilled nursing facility, inpatient hospital, home health, or outpatient rehabilitation therapy.

Not only does CMS recognize that this proposed methodology would exclude most hip and knee patients, in its commentary to the proposed rule CMS frankly states that it believes reimbursement, and not medical necessity, has driven the decision to admit such patients to IRFs:

“We acknowledge that the industry has interpreted polyarthritis to include hip and knee joint replacement cases and these should be included in the conditions counted in existing § 412.23(b)(2). Although some joint replacement cases are currently being treated in IRFs, we are not aware of any research that identifies the factors determining which patients are

more appropriately treated in the intensive inpatient rehabilitation setting provided in an IRF. Although it has been asserted that patients at risk for thrombosis, pressure ulcers, or infections should be treated in IRFs, all hip and knee joint replacement patients are at risk for those conditions. Likewise the presence of comorbidities such as diabetes and hypertension are common conditions that can generally be managed in the outpatient setting. We believe that there have been strong reimbursement incentives to send patients to IRFs and that these considerations have influenced the choice of setting for patients' care. We welcome data or studies that might provide evidence about whether certain patients had better outcomes as a result of care in IRFs.”⁶

Thus CMS is laying down a challenge to inpatient rehabilitation providers. If the providers want hip and knee replacements to be included in the rule, they will have to provide hard proof that the IRF is really the best setting for such patients.

Conclusion

CMS' “65/75 percent split rule” as proposed will allow inpatient rehabilitation providers more flexibility in establishing their patient mix while still remaining in compliance with the rule. By allowing providers to use a 65 percent compliance target and also using comorbidities to establish compliance for a projected 3-year period, it will also allow the many providers who are currently not in compliance time to adjust their patient mix so as to establish compliance.

CMS has made clear, however, that it still expects providers to abide by what has always been a watchword of the rehabilitation industry: The right patient, in the right setting, for the right time. If outpatient rehabilitation is really the most appropriate setting for hip and knee replacement patients, that is where the therapy should be provided. If such patients do achieve better outcomes in the inpatient setting, providers should be able to meet CMS' challenge and produce the hard numbers to back up this claim.

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⁶ 68 Fed. Reg. at 53271-72.