

# **Where Has Subacute Rehabilitation Gone?**

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Health care providers are increasingly faced with the challenge of maintaining quality of care in a complex regulatory and financial environment. Providers must meet the specific needs of a diverse patient population. Establishment of a continuum of care has been recognized as an effective way to meet varied patient needs that range from intensive care to outpatient services. Rehabilitation patients in particular require a full continuum of care to meet each patient's individual tolerance for therapy and clinical needs.

Health systems have addressed a portion of their continuum of care needs by establishing rehabilitation hospitals and distinct part hospital units. However, not all patients with rehabilitation needs who require inpatient care are appropriate for rehabilitation hospitals and units. Thus, health care providers have increasingly looked to develop subacute rehabilitation programs. This article will explore the status of "subacute rehabilitation" as a healthcare venue and will discuss the current Medicare payment methodology for patients who require inpatient subacute rehabilitation.

## **The Subacute Rehabilitation Component**

"Subacute rehabilitation" is a term developed by the healthcare industry that has been applied to a broad range of programs. Generally, "subacute rehabilitation units" refer to programs developed to provide inpatient rehabilitation to patients following their acute care hospital stays. However, the Medicare program does not have a separate reimbursement system or payment classification for such

distinction. Therefore, subacute rehabilitation units must meet the Medicare conditions of participation for skilled nursing units in order to participate in the program and receive reimbursement for care provided to Medicare beneficiaries.

Generally, subacute is defined by the American Health Care Association and the Joint Commission on Hospital Accreditation of Healthcare Organizations as "comprehensive inpatient care designed for someone who has an acute illness, injury, or exacerbation of a disease process. . . . Subacute is generally more intensive than traditional nursing facility care and less than acute care."<sup>1</sup>

The Medicare program reimburses rehabilitation care provided in rehabilitation hospitals and units and in skilled nursing facilities or units (SNFs). Subacute rehabilitation is provided in SNFs if patients requiring rehabilitation cannot meet the admission criteria of a rehabilitation hospital or unit.

### **Medicare-Certified Rehabilitation Hospitals and Units: Payment Methodology, Patient Acuity and the Three-Hour Rule**

Rehabilitation hospitals and units have recently received heightened attention as a result of the Centers for Medicare and Medicaid Services finalizing the prospective payment system (PPS) for inpatient rehabilitation facilities (IRFs). Under this system, cases are assigned to a Case-Mix Group (CMG) based on the clinical traits of the Medicare patient. Payments are then adjusted according to case-specific factors and facility factors such as wage adjustments and the treatment of low-income patients.

Significantly, the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) requires that the total payments for IRF PPS must be equal the amount of payments that the facilities would have received under the cost-based system for fiscal year 2002. Budget neutrality at the initiation of the PPS has allayed some concerns regarding the financial ramifications of the new system.

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<sup>1</sup> Medicare and Medicaid Guide (CCH) ¶42,645.

One important area that has not been changed by the new payment system for IRFs is the set of criteria that must be met to exempt IRFs from the acute care hospital PPS. These criteria define the patient population that IRFs must treat in order to obtain exemption and remain exempt from acute PPS. Consequently, IRF admission criteria seek to limit admission to patients who meet the patient population requirements.

To be eligible for admission to a Medicare-certified rehabilitation hospital or unit, patients must require “intensive rehabilitative services.”<sup>2</sup> The general threshold for establishing the need for inpatient hospital rehabilitation services is that the patient must require and receive at least 3 hours of physical and/or occupational therapy per day. The therapy must be provided as treatment for one or more of the following conditions:

- (1) Stroke
- (2) Spinal cord injury
- (3) Congenital deformity
- (4) Amputation
- (5) Major multiple trauma
- (6) Fracture of femur (hip fracture)
- (7) Brain injury
- (8) Polyarthritis, including rheumatoid arthritis
- (9) Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease
- (10) Burns

The above diagnoses are considered when assigning patients to appropriate CMGs. Please note that the three-hour rule does not require that patients receive at least three hours of therapy per day, seven days per week. The provision of three hours of rehabilitation services for at least five days per week satisfies the requirement for “daily” therapy services.

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<sup>2</sup> 42 CFR §412.23(b)(2).

Of course, many patients who no longer require acute inpatient care but have rehabilitation needs cannot withstand or do not require three hours of therapy services per day, five days per week. In addition, such patients may not be appropriate for a rehabilitation hospital or unit due to their diagnoses. In such instances, it may be appropriate for these patients to receive treatment in a SNF that offers a subacute rehabilitation program.

### **Medicare Payment for Rehabilitation Patients in SNFs**

Medicare reimburses SNFs under a prospective payment system that is adjusted according to resources required by each patient. Per diem payments for each patient are case-mix adjusted using a resident classification system, Resource Utilization Groups (RUGs). RUGs are based on data from resident assessments (Minimum Data Set). Consequently, rehabilitation patients are placed in rehabilitation RUGs, in large part, according to the amount of rehabilitation they require.

There are five rehabilitation RUGs categories that are delineated by the number of minutes of rehabilitation that is provided to the patient. The rehabilitation categories include:

Ultra High	Treatment minimum- 720 minutes weekly. At least 2 disciplines: One discipline at least 5 days per week and 1 discipline 3 days per week.
Very High	Treatment minimum- 500 minutes weekly. At least 1 discipline 5 days per week.
High	Treatment minimum- 325 minutes weekly. At least 1 discipline 5 days per week.
Medium	Treatment minimum- 150 minutes weekly. Five days across 3 disciplines.
Low	Treatment minimum- 45 minutes weekly over at least 3 days.

The highest Medicare RUGs rates are for beneficiaries who require rehabilitation. The rates below illustrate that the per diem payment for the highest rehabilitation category for an urban SNF, discounting any adjustment for the wage index, is \$488.39. The amounts below were calculated for fiscal year 2002 using national rates for SNFs located in urban areas. The rates reflect a 10.7 percent adjustment which consists of a 4 percent adjustment from section 101(d) of the Balanced Budget Refinement Act (BBRA) of 1999 and a 6.7 percent adjustment from section 314 of BIPA 2000.

**FISCAL YEAR 2002 RUGS RATES FOR URBAN SNFS  
WITH BBRA 1999 AND BIPA 2000 ADD-ONS**

<b>Rehabilitation Level</b>	<b>RUG Group</b>	<b>Per Diem Payment</b>
Ultra High	RUC	\$488.39
	RUB	\$434.81
	RUA	\$408.78
Very High	RVC	\$379.34
	RVB	\$365.55
	RVA	\$330.34
High	RHC	\$352.78
	RHB	\$322.16
	RHA	\$293.07
Medium	RMC	\$349.75
	RMB	\$309.95
	RMA	\$290.04
Low	RLB	\$279.40
	RLA	\$231.94

While Medicare’s prospective payment system for SNFs has proven to be a challenge for many providers, it does recognize the resource demands inherent in treating rehabilitation patients. Thus, subacute rehabilitation provided in the SNF setting is a practical addition to a health system’s continuum of care because it can meet the needs of

patients who no longer require acute care but do not otherwise qualify for admission to a distinct part rehabilitation unit.

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