

First You Say You Do, Then You Don't

Inpatient Rehab Providers Struggle to Reconcile the 75 Percent Rule and Local Coverage Determinations

by

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Introduction

For the past three years, we have been following in this column the often tortured history of Medicare's "75 percent rule" for inpatient rehabilitation facilities or "IRFs"¹ When, over the vigorous objections of many in the provider community, CMS issued its final amendments to the 75 percent rule on May 7, 2004, one may have supposed that IRF providers would at least know what kinds of diagnoses they should seek for their facilities and which they should avoid. Unfortunately, the providers are also required to follow "Local Coverage Determinations" or "LCDs" that are issued by their fiscal intermediaries. As we shall see the 75 percent rule and the LCDs are not always easy to reconcile.

The 75 Percent Rule

Since its implementation in 1983, the inpatient acute care hospital PPS has exempted from its provisions freestanding rehabilitation hospitals and inpatient rehabilitation units of general hospitals that meet certain criteria. One of these criteria is that 75 percent of the exempt IRF's patients,² during its most recent twelve-month cost reporting period, must have a diagnosis that falls into one or more categories. As revised in 2004, the "new" 75 percent rule retains nine of the diagnosis categories that have been included in the rule since it was first implemented:

- Stroke
- Spinal cord injury
- Congenital deformity
- Amputation
- Major multiple trauma
- Fracture of femur (hip fracture)
- Brain injury

¹ The term "inpatient rehabilitation facility" or "IRF" encompasses both rehabilitation hospitals and distinct part rehabilitation units of hospitals.

² The required percentage levels under the 75 percent rule are currently being phased in. For cost reporting periods beginning on or after July 1, 2005, the required compliance percentage is 60. The required level rises to 65 percent for cost reporting periods beginning on or after July 1, 2006, and 75 percent for cost reporting periods beginning on or after July 1, 2007.

- Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease
- Burns³

Newly added to the 75 percent rule are provisions replacing the former diagnosis category of “polyarthritis” with three groups of conditions that will more precisely identify the types of arthritis-related conditions appropriate for care in a rehabilitation facility.

The most controversial addition to the new rule, however, was a special provision dealing with knee and hip replacements. Hip and knee replacements count as qualifying conditions if one of the following three requirements 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.

Whether or not they agreed with the revisions, the 75 percent rule at least gave IRF providers a “bright line” rule that they could use in determining whether their patients were appropriate for IRF admission. However, such was not the case with the LCDs that the fiscal intermediaries were busy preparing at the same time that CMS’ national office was amending the 75 percent rule.

The LCDs and Medical Necessity

Unlike the 75 percent rule, the LCDs do not (at least not ostensibly) provide a direct statement about which diagnoses are appropriate for IRF services. Instead, they are intended to provide guidance for making a determination whether any given patient, regardless of diagnosis, meets the overriding criteria for determining whether inpatient rehabilitation is medically necessary. This article will focus on the LCD issued by Mutual of Omaha, because it is representative of all the LCDs being issued by fiscal intermediaries, Mutual of Omaha is the largest fiscal intermediary, and its LCD⁴ was the first to go into effect.

The LCD’s general criteria for medical necessity are not controversial, since they generally reiterate CMS’ national guidance on the subject:

1. The patient must require the 24 hour availability of a physician with special training or experience in the field of rehabilitation;
2. The patient must require the 24 hour availability of a registered nurse with specialized training or experience in rehabilitation;

³ 42 C.F.R. §§ 412.23(b)(2), 412.29(a), 412.30(b),(c).

⁴ LCD for Inpatient Rehabilitation Services, L19890, effective May 14, 2005.

3. The patient must require and receive at least three hours a day of physical and/or occupational therapy; and
4. The IRF must have program services developed using a coordinated multidisciplinary approach.

Compliant or Not?

If the LCD had contented itself with simply stating the criteria for meeting medical necessity it probably would have not been so controversial. However, the LCD goes on to state the fiscal intermediary's opinion regarding whether certain types of diagnoses generally would require inpatient rehabilitation. For example, the LCD states that inpatient rehabilitation is typically **not** covered for:

1. Single extremity deficits (except amputations);
2. Simple fractures;
3. Joint replacement;
4. Compression fractures and laminectomies/fusions;
5. Diffuse weakness or general debility;
6. Post –op recovery; and
7. Niche rehabilitation (coma, cognitive, cardiac, pulmonary, pain, etc.)

Perhaps more disturbingly, the LCD also states that certain conditions that are within the 75 percent rule should “rarely” be treated in an IRF. For example, the LCD states that, “Recovery from a single hip fracture rarely requires inpatient rehabilitation.” The same is true for amputation of non-extremity parts (e.g. ears, breast, jaw, panniculi) and amputations of upper extremities or lower extremities that do not require prosthetic fittings.

These statements would seem to put the LCD in conflict with the 75 percent rule, which, according to CMS was designed to delineate a facility primarily engaged in providing intensive rehabilitation services as opposed to general medical and surgical services with some rehabilitation services. It is certainly reasonable for a provider to ask, “If hip fractures and amputations are conditions that CMS says are hallmarks of an inpatient rehabilitation facility, why does the fiscal intermediary oppose their admission?”

Documentation of the Medical Necessity of Intensive Services is the Touchstone

In reconciling the 75 percent rule with the LCDs, it is important to keep in mind that nowhere does the LCD impose an absolute prohibition on admitting any particular diagnosis to an IRF. Rather, the LCD is saying that the typical patient with that condition would not require that level of service. The solution is to thoroughly document, in the facility's own screening tools, the Medicare Patient Assessment Instrument, and in the admitting physician's history and physical report, the particular circumstances of that patient that make an IRF admission a

medical necessity. As the Mutual of Omaha LCD states, “In all instances it is not the specific diagnosis that determines the medical appropriateness of the inpatient venue but rather it is the requirement for an intensive level of constant care as documented in the medical record.”

Indeed, it is the requirement that the medical necessity of the intensive services particular to an IRF be documented that permeates the LCD. For example, the LCD states that one of the hallmarks of medical necessity is that the therapy cannot be provided in a less intensive setting due to the need for 24-hour a day specialized nursing, the need for frequent physician assessment and intervention, or the need for specialized equipment at such frequency and duration as to make outpatient treatment impractical. Furthermore, in its discussion of each type of condition, whether or not that condition is one that the LCD states should be found in an IRF “frequently” or “rarely,” the LCD states, “Documentation must support the need for the intensity of an inpatient setting and the need for a multidisciplinary team approach.”

The best approach for addressing the LCDs, therefore, is not to reject out of hand the admission of any particular diagnosis to the IRF, but rather to ensure that all admissions, regardless of condition, are grounded in documentation that thoroughly supports the intensity of services to be offered.

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