

## THE GAO TELL CMS TO REBOOT

By

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As we have discussed in previous articles, CMS' attempts to update the "75 percent rule," which specifies the requirements for qualification as an inpatient rehabilitation facility ("IRF"), have been fraught with controversy. As a result, Congress, in the Consolidated Appropriations Act of 2005, directed CMS not to declassify any IRFs on the basis of non-compliance with the 75 percent rule until the Government Accountability Office ("GAO") issued a report assessing whether the list of compliant conditions in the 75 percent rule are a clinically appropriate standard for defining IRF services, and, if not, what additional conditions should be added to the list. The Act gave CMS 60 days to respond to the report by determining that either (1) the current rule is not inconsistent with GAO's recommendations, or (2) issues an interim rule revising the 75 percent rule in accordance with the report's recommendations. As we shall see, GAO's long-awaited report, which was issued at the end of April, 2005, instructs CMS that it does, indeed, need to "reboot" the 75 percent rule in terms of defining more specific criteria to classify IRFs. Nevertheless, the report provides little relief to IRFs who were hoping that the report would open the door to an expanded list of compliant conditions. On the contrary, if anything, the report tells CMS that it needs to be even more restrictive.

The 75 percent rule as finalized by CMS in 2004 specifies 13 conditions that, in CMS' view, characterize an IRF. The 13 conditions are:

- stroke;
- spinal cord injury;
- congenital deformity;
- amputation;
- major multiple trauma;
- hip fracture;
- brain injury;
- neurological disorders;
- burns;
- certain active polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies;
- certain systemic vasulidities with joint inflammation;
- severe or advanced osteoarthritis involving two or more major weight-bearing joints meeting certain criteria; and
- knee or hip joint replacements where the patient must have undergone a knee or hip joint replacement, or both, during an acute care hospitalization immediately preceding the inpatient rehabilitation stay and also have had a bilateral

procedure, or is at least 85 years of age or older, or is extremely obese with a body mass index of at least 50.

In conjunction with the list of conditions, CMS published a phase-in schedule of percentages of the IRF's patients who must have one or more of the 13 conditions for the facility to qualify as an IRF. The required percentages are:

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.

In addition, for cost reporting periods beginning before July 1, 2007, if the patient has one or more comorbidities that fall within the 13 listed conditions, and those comorbidities by themselves would make inpatient rehabilitative therapy medically necessary, the IRF may count that patient as qualifying under the rule. However, for cost reporting periods beginning on or after July 1, 2007, comorbidities may not be used to determine compliance with the 75 percent rule.

The GAO report notes that "IRF compliance with the requirements of the rule has been problematic." CMS' own data indicated that in 2002 only 13 percent of IRFs had at least 75 percent of patients in one of the 10 conditions that the rule specified at that time. GAO's study found that in fiscal year 2003, less than half of all IRF patients were admitted for one of the 13 conditions that comprise the present rule, although the total increased to over three-fifths if comorbidities were counted. However, based on 2003 admissions, only six percent of IRFs would be compliant with the rule if the percentage requirements increased to 75 percent as they will for cost reporting periods beginning on or after July 1, 2007.

Unsurprisingly the main reason for these difficulties in compliance was orthopedics. The GAO found that almost half of the patients that were admitted to IRFs for conditions that are not on the compliant list were orthopedic patients, and among those the largest group was joint replacement patients. That finding, however, did not lead the GAO to offer providers the comfort of a recommendation that joint replacements be added to the list of compliant conditions. Instead, the GAO was keenly aware of the difference in reimbursement between inpatient rehabilitation and other settings:

"IRFs need to be correctly classified to be distinguished from settings in which less intensive rehabilitation is provided because the difference in payments to IRFs and payments to these other settings can be substantial. For example, the estimated Medicare per case payment in 2004 for a patient who underwent a major joint and limb replacement of a lower extremity was \$17,135 to an IRF and \$6,165 to a SNF. . . . Therefore, if IRFs are not correctly classified, Medicare is at

risk of making large overpayments to incorrectly classified facilities. Medicare is also at risk of overpayment for individual patients in an IRF if patients are admitted who could be treated in a less intensive setting.”

More importantly the GAO found that, although some joint replacement patients may have comorbidities that require inpatient therapy and treatment, few single joint replacement patients needed the intensity of services offered by an IRF.

Indeed, far from recommending that any conditions be added to the 75 percent rule list, the GAO report recommends that CMS take a number of specific actions to *further refine* the rule. These recommended actions include:

- Ensuring that fiscal intermediaries routinely conduct targeted reviews of the medical necessity of IRF admissions;
- Conducting additional activities to encourage research on the effectiveness of inpatient therapy and the factors that predict the need for such therapy; and
- Utilizing the results of those reviews and research *“to refine the rule to describe more thoroughly the subgroups of patients within a condition that require IRF services, possibly using functional status or other factors in addition to condition.”* (emphasis added).

Thus, the GAO report does not suggest that CMS eliminate any of the conditions in the current rule, nor does it suggest that any be added. According to the report, the GAO contracted with the Institute of Medicine to interview experts regarding the desirability of adding conditions to the list, but the Institute could find no consensus on any particular condition that was suitable for intensive inpatient treatment. Instead, the Institute found that CMS should “reboot” its thinking about IRF qualification in such a way as to ensure that condition alone is not the sole criteria for differentiating patients that would benefit from an inpatient setting from those who would benefit from another setting, such as outpatient rehabilitation or skilled nursing. According to the GAO, CMS’ goal should be to define “subgroups” of the existing conditions that would include a variety of patient-specific criteria such as functional status. The exact nature of these subgroups, however, the report leaves for CMS’ research to determine.

Whatever criteria emerges from the report’s recommendations and CMS’ follow-up, providers can be certain that it will not be a more inclusive 75 percent rule. In a letter accompanying the GAO report, CMS Administrator Dr. Mark McClellan states that, while CMS expects to follow the GAO’s recommendation to define subgroups of the 13 conditions, it will consider doing this carefully, “as we expect this would result in a more restrictive policy than the present regulations.”

In conclusion, the GAO report, far from representing relief for IRF providers with heavy orthopedic populations, provides clear support for CMS’ effort to steer inpatient rehabilitation back to its roots in such diagnostic categories as stroke, neurology and spinal cord injury. It remains to be seen whether the provider community will finally go along with this effort or attempt to reboot CMS once more through Congress.

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