

**Inpatient Rehabilitation Facilities –
Relief from 75% Compliance Threshold Full Implementation**

By:

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Inpatient Rehabilitation Overview

Inpatient rehabilitation facilities (IRFs) are a critical venue in the post acute continuum of care. An IRF provides specialized services to patients with functional deficits. Medicare pays IRFs at a higher rate than other health care providers because IRFs are designed to offer specialized rehabilitation care to patients with the most intensive needs.

The “75 percent rule” has been part of the criteria for defining IRFs since the implementation of the hospital inpatient prospective payment system (IPPS) in 1983. The purpose of the criteria is to ensure that IRFs, which are exempt from the hospital inpatient PPS, are primarily involved in providing intensive rehabilitation services to patients that cannot be served in other, less intensive rehabilitation settings.

75% Rule Background

One of the special types of hospitals excluded from the Medicare Inpatient Prospective Payment System (IPPS) is an inpatient rehabilitation facility (IRF). Medicare payments to IRFs are based on the IRF PPS that was implemented on January 1, 2002. The conditions for payment under the IRF PPS are specified at 42 CFR §412.604.

The implementation of the IRF PPS did not change the regulations and procedures applicable to entities seeking classification as an IRF. In order to receive payment under the IRF PPS, a hospital or unit of a hospital must first meet the requirements to be classified as an IRF in accordance with subpart B of Part 412. This includes meeting the requirement under §412.23(b)(2), which was commonly referred to as the “75 percent rule” or the “compliance percentage threshold.”

The 75 percent rule requires that during a facility’s cost reporting period, at least 75 percent of the IRF’s patients required treatment for one of the following specific conditions:

1. Stroke;
2. Spinal cord injury;

3. Congenital deformity;
4. Amputation;
5. Major multiple trauma;
6. Fractures of femur (Hip fracture);
7. Brain injury;
8. Neurological disorders, including multiple sclerosis, motor neuron diseases, Polyneuropathy, muscular dystrophy, and Parkinson's disease;
9. Burns;
10. Active polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies;
11. Systemic vasculidities with joint inflammation;
12. Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints;
13. Knee or Hip joint replacement or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meet one or more of the following specific criteria:
 - The patient underwent a bilateral hip or knee replacement during an inpatient hospital stay immediately preceding the IRF admission;
 - The patient is extremely obese, with a Body Mass Index of at least 50 at the time of admission to the IRF; or
 - The patient is age 85 or older at the time of admission to the IRF.

The final *phase in* schedule for the 75% Rule mandated by CMS was as follows (prior to the implementation of new legislation in December 2007):

- 60% for cost reporting periods beginning on or after July 1, 2005 and before July 1, 2007;
- 65% for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2008; and
- 75% for cost reporting periods beginning on or after July 1, 2008.

Each facility's cost reporting period determines what data review period will be analyzed. In some cases the compliance review period may be in two separate sets of data. Each period has to make the threshold individually. If the facility fails in either period the rehabilitation program will lose its certification. CMS publishes a Chart with a Compliance Review period which demonstrates each upcoming cost report start date and the corresponding compliance review period(s).

2008 IRF Final Rule

On July 31, 2007 the Centers for Medicare and Medicaid Services (CMS) issued its Medicare inpatient rehabilitation facility (IRF) final rule for FY 2008. The rule updated payment rates and modified payment policies for services furnished to Medicare beneficiaries for discharges occurring on or after October 1, 2007, through September 30, 2008.

The following table summarizes the key factors implemented in the 2008 IRF Final Rule:

| FY 2008 IRF Final Rule Updates <i>(Effective October 1, 2007)</i> |
|--|
| <ul style="list-style-type: none">• A market basket update of 3.2% resulting in an estimated \$150 million increase in Medicare IRF Payments.• Update to wage index including a policy for rural areas without hospital wage data.• Increases outlier threshold from \$5,534 in FY 2007 to \$7,362 in FY 2008.• Maintains 75% Threshold Rule with no change to full implementation schedule.• Expiration of allowing comorbidities to be used in conjunction with the 13 designated medical conditions to meet the 75% Rule on July 1, 2008. |
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Notably, the 2008 Final Rule provided a market basket update of 3.2% while simultaneously maintaining the 75% threshold rule full implementation schedule and disallowed the use of comorbidities to satisfy the compliance threshold.

Industry Reaction

As a result of the 2008 Final IRF Rules, lobbyists for the IRF industry urged lawmakers that the 75% rule limited patient access to inpatient rehabilitation hospitals. The IRF Industry also argued that the Rule should be appropriately refashioned to maintain and preserve access to ***safe*** and ***effective*** inpatient rehabilitative healthcare that allows patients to regain or maintain their maximum level of independence in their daily lives. More focus should be placed upon the medical and rehabilitative needs of patients, with less focus on their medical diagnoses or conditions alone.

Accordingly lawmakers pushed for the passage of legislation that would ensure beneficiary access to inpatient rehabilitation facility services by addressing the 75 percent rule. This rule has been criticized as too blunt an instrument for ensuring that appropriate patients receive care at these facilities.

As outlined above, under the current law, a percentage of Medicare patients must have at least one of 13 listed medical conditions in order to be classified as an inpatient rehabilitation facility. This percentage or compliance threshold is currently at 65 percent and would be fully phased in by July 1, 2008.

Legislative Response and Relief – The Medicare, Medicaid, and SCHIP Expansion Act of 2007

On December 29, 2007 President Bush signed into law S. 2449, the Medicare, Medicaid, and SCHIP Extension Act of 2007. This Act contains several provisions important to the rehabilitation industry including the following:

- **Extension of the therapy cap exceptions process** through June 30, 2008
- **Increase in the physician payment rate**, which replaces the scheduled 10.1% cut to the Medicare physicians reimbursement rate in 2008 with a 0.5% increase through June 30, 2008
- **Extension of the Physician Quality Reporting Initiative (PQRI)**
- **Extension of the floor of 1.000 on work geographic adjustment index (GPCI)** through June 30, 2008
- **Extends the State Children's Health Insurance Program (SCHIP) through March 31, 2009**, and provides adequate funding to states for the purpose of maintaining their current enrollment through that date.

Most importantly, the legislation permanently freezes the inpatient rehabilitation facility (IRF) services compliance threshold at 60% effective for cost reporting periods starting July 1, 2006, and allows comorbid conditions to count toward this threshold.

While the Medicare, Medicaid, and SCHIP Extension Act of 2007 provides relief from the scheduled full implementation of the compliance threshold and continues to allow comorbid conditions to count toward the threshold, the Act also reduces the market basket update factor at 0% starting April 1, 2008.

Under the changes adopted by the Medicare, Medicaid, and SCHIP Extension Act of 2007, inpatient rehabilitation hospitals and units should not be forced to close more beds or decrease staff or services. Instead the rehabilitation hospitals and units can focus on providing high quality inpatient rehabilitative care to patients who need it. Additionally, the Act ensures that patients with secondary medical ailments continue to have access to inpatient rehabilitative care.

Despite the relief the Act provides relative to the compliance threshold and comorbidity issue, the Act reduces the 2008 IRF Final Rule 3.2% market basket increase to a 0% increase. Additionally, the Congressional Budget Office (CBO) has estimated an approximate \$4 billion payment reduction to payment for inpatient rehabilitation facility (IRF) services over the next ten years. This estimate is a result of a minimal percentage decrease for IRF payments by Medicare over the next 10 years. However, it is uncertain how this estimate will play out practically given that the compliance threshold has been frozen.

As always, Medicare's updates to the IRF market basket occur annually and the true financial impacts resulting from the changes in the Medicare, Medicaid, and SCHIP Extension Act of 2007 can only be seen as Medicare updates the payment rates annually. Ultimately, the relief provided by halting the full implementation of the 75% compliance threshold that was scheduled for July 1, 2008 is promising news for inpatient rehabilitation facilities.

Summary of Medicare, Medicaid, and SCHIP Extension Act of 2007 Impact on Payment for Inpatient Rehabilitation Facility (IRF) Services

- Sets the market basket update factor at 0% for April 1, 2008 through FY 2009.
- Permanently freezes the inpatient rehabilitation services compliance threshold at 60%, effective for cost reporting periods starting on or after July 1, 2006.
- Continues to allow comorbid conditions to count toward the 60% compliance threshold for cost reporting periods beginning on or after July 1, 2007.
- Requires the Secretary to study beneficiary access to inpatient rehabilitation services and care at IRFs and to make recommendations for classifying inpatient rehabilitation facility hospitals and units.

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