

## **The LTACH in Rehab Clothing**

**By**

**Cherilyn G. Murer, JD, CRA**

As our past articles have indicated, long term acute care hospitals (LTACHs) recently have been the subject of much scrutiny from the Centers for Medicare and Medicaid Services (CMS). Hospital-within-a-Hospital (HwH) LTACHs, in particular, have faced daunting new regulations in terms of the percentage of patient referrals that they may accept from the host hospital. The HwH regulations, however, did nothing to alleviate CMS' general concerns with the LTACH venue—whether freestanding or HwH—particularly its concern that some LTACHs are being used as inappropriate substitutes for skilled nursing facilities (SNFs) and inpatient rehabilitation facilities (IRFs). Ironically, the solutions that CMS is studying may serve to ease the compliance burden on HwH LTACHs, at least insofar as they replace the restrictions on referral sources. Interestingly, the solutions that CMS envisions are drawn directly from Medicare's experience with IRFs. Unfortunately, some of the proposed solutions seem to have been adopted from the IRF experience without giving sufficient thought to the essential differences between IRFs and LTACHs. The provider community should take advantage of the current opportunity to ensure that any final rule promulgated by CMS reflects thoughtful consideration of these differences.

The direction that CMS is taking with respect to LTACHs is primarily being driven by a June 2004 report by the Medicare Payment Advisory Commission (MedPAC), which resulted from a one year and a half study performed by the Commission. That report made a number of significant recommendations for the implementation of new conditions of participation that, instead of imposing arbitrary limits on specific sources of patient referral (in particular the host hospital of an HwH LTACH), focus on patient and facility specific clinical criteria. As we shall see, these criteria have a distinct correlation to the criteria currently used by CMS to determine the eligibility of IRFs.

MedPAC's recommendations are:

- 1) LTACH patients should have a good chance of improvement;
- 2) CMS should formulate patient-specific criteria for every admission;
- 3) CMS should restrict 85% of admissions to specific Major Diagnostic Groups to be defined by CMS;
- 4) Preclude LTACH specialization in acute care rehabilitation except for select LTACHs that have documented and lengthy history of providing rehabilitation services;
- 5) Require Quality Improvement Organizations (QIOs) to review medical necessity and quality of care;
- 6) Monitor compliance with new patient-specific criteria when implemented
- 7) Formulate new LTACH facility-specific criteria that:

- a) Prescribe the level of physician and nurse availability and capabilities;
  - b) Require use of a standard patient assessment tool; and
  - c) Require documented patient-specific multidisciplinary treatment plans of care
- 8) Investigate ways to provide acute care hospitals with financial incentives to continue care and not discharge to an LTACH; and
- 9) Expand HwH LTACH reporting requirements to include reporting the address and provider numbers of their host hospitals to their fiscal intermediaries.

Medicare's rehabilitation experience is evident in several of these recommendations. First, and perhaps most remarkable, is the recommendation that an LTACH patient have a good chance for improvement. This is quite similar to the requirement that an IRF patient have rehabilitation potential in terms of being able to tolerate and benefit from three hours of intensive therapy a day. The key distinction, of course, is that at least until now LTACHs have always been defined as being just like any other acute care hospital except that their patients are expected to average a 25-day length of stay. Requiring an improvement potential moves the LTACH much closer to a rehabilitation type venue. Doubtless this recommendation derives from MedPAC's concern that LTACH's are being used as a high reimbursement substitute for SNFs, but it goes directly against the purpose for which Congress recognized LTACHs in the place: To provide an appropriate forum in the continuum of care in which to treat "the sickest of the sick."

The recommendation that 85% percent of admissions be restricted to Major Diagnostic Groups to be defined by CMS is, of course, directly derived from the "75% rule" governing IRFs. Unfortunately, the parameters of just what rehabilitation diagnoses should be included in the 75 percent rule have been a subject of bitter controversy for the past three years, with no firm resolution in sight. At least theoretically it should be easier to arrive at a consensus on the diagnoses appropriate for IRFs than for LTACHs. After all, only a certain number of medical conditions are susceptible to improvement by the application of intensive therapy. LTACHs, on the other hand, like their short-term acute hospital counterparts are supposed to be able to address the entire spectrum of medical conditions. That is why the diagnosis related groups (DRGs) of the LTACH's prospective payment system are a mirror image of those of the short-term acute hospital's. If CMS and the provider community cannot agree on the diagnoses appropriate for a rehabilitation facility, one wonders how a consensus is possible for a broad-based forum like an LTACH.

The recommended preclusion of allowing new LTACHs to specialize in treating rehabilitation diagnoses provides a "flip side" to the MedPAC's IRF-derived recommendations. While recognizing that several established rehabilitation hospitals are, in fact, certified by Medicare as LTACHs, this recommendation reflects MedPAC's and CMS' fear that LTACHs may be used a substitute for IRFs especially in light of CMS' planned enforcement of the revised 75 percent rule. While this recommendation should not prove too onerous to existing LTACHs who generally do not specialize in rehabilitation patients anyway, due to length of stay and medical necessity considerations, CMS should be careful that it does not prohibit a new LTACH from ever specializing in rehabilitation under any conditions, and that it does not define "specialize"

in a manner so restrictive as to preclude an LTACH from accepting any rehabilitation patients at all.

The facility specific recommendations, on the other hand, should not only be appropriate for LTACHs, they should fit relatively easily into the practices and procedures already being utilized by diligent LTACHs. For example, as MedPAC's own report recognizes that most LTACHs provide a level of clinical service that is similar to a short-term acute hospital's "step-down" ICU. As a result, LTACH patients are already receiving a level of nursing care substantially greater than that of a typical hospital medical-surgical unit. As to physician participation, since an LTACH is an acute care hospital, the LTACH patients' physicians are already making daily rounds just as they do in a short-term acute setting. Thus, it is unlikely that any prescribed level of physician or nursing participation would substantially alter existing LTACH practices.

The recommended utilization of a standard patient assessment tool is, of course, directly derived from the Patient Assessment Instrument currently used for IRFs. Of course, any patient assessment tool utilized for LTACHs would have to be carefully tailored to meet the particular requirements of the LTACH venue. However, the information that such an instrument would contain will already be in the patient files of LTACHs that diligently document the medical necessity of their patient admissions.

Finally, the recommendation that LTACHs develop and document multi-disciplinary plans of care for each patient are also derived from the similar requirement for IRF patients. Again, diligent LTACHs not only utilize the combined experience of medical, nursing, therapy, and social worker/discharge planning staff in developing plans of care for their patients, they thoroughly document these plans in all of their patient charts. Thus, any such requirement should fit easily into already established practices at such LTACHs.

In sum, CMS is pursuing a laudable goal in seeking to re-direct the LTACH conditions of participation from arbitrary limitations on referral sources to patient and facility-specific criteria. As they pursue this effort, however, the provider community should make ensure that CMS understands that, although the IRF experience provides many useful comparisons for LTACHs, it is possible to carry the analogy too far. Any criteria developed for LTACHs should be carefully crafted with a view toward the particular demands and requirements of the particular patients that an LTACH is designed to serve.

#### About the Author:

Cherilyn G. Murer, J.D., C.R.A. is CEO and founder of the Murer Group, a legal based health care management consulting firm in Joliet, IL, specializing in strategic analysis and business development. Ms. Murer may be reached at (815) 727-3355 or viewed on web site: <http://www.murer.com>