

Multi-Venue Opportunities for Orthopedic Services

By

Cherilyn G. Murer, JD, CRA

The move from traditional, acute inpatient hospital care to outpatient and post-acute venues has created opportunities for healthcare providers to offer their services in a number of different venues. Wise management of these opportunities enables providers to match the venue with patient. The result is fulfillment of that most cherished goal for all healthcare providers: The right patient, in the right bed, for the right reimbursement.

As much as any other specialty, orthopedic service providers are in a position to take advantage of the opportunities available in multiple venues. However, in deciding which patients should be placed in which venue, it is important to realize that each venue has its limitations as well as its advantages. In this article, therefore, we will look at the advantages and limitations of providing orthopedic services in several venues: Ambulatory Surgical Centers (ASCs), Comprehensive Outpatient Rehabilitation Facilities (CORFs), Inpatient Rehabilitation Facilities (IRFs), and Long Term Acute Care Hospitals (LTACHs).

ASCs

ASCs offer an obvious alternative to inpatient surgery for appropriate orthopedic patients. ASCs have proven attractive to both physician investors and healthcare systems because they offer a venue of appropriate care for many surgical procedures that do not require extensive post-operative care while avoiding many of the high costs associate with staffing and supplying inpatient surgical suites and associated aftercare.

Medicare pays for many orthopedic procedures performed in ASCs. The covered procedures are identified in the "ASC List" published in the Federal Register. Procedures are classified for payment in 9 groups ranging from a low of \$333 (group 1) to a high of \$1,339 (group 9). One of the biggest limitations on ASCs as an orthopedic venue is that procedures that would cost less than \$333 are not covered, even though they would be medically appropriate for an ASC setting. According to CMS, such low-cost procedures are not covered, because "they would be significantly overpaid in the lowest ASC payment group, which could create an incentive to shift these procedures [from a hospital] to an ASC setting."

Another major limitation on ASC use for orthopedic surgery is that Medicare ASC regulations prohibit reserving beds for observation if the same surgical suite is used for ambulatory surgery. In other words, Medicare prohibits the use of planed observation beds in ASCs. As CMS stated in a letter to state survey agencies, dated March 11, 2004:

“Overnight stays following surgery in an ASC should be infrequent and only occur in cases where an unanticipated medical condition requires medical observation or care within the capabilities of the ASC. . . . An ASC that routinely provides overnight recovery stays, regardless of the payment source, may no longer meet the regulatory definition of an ASC and will jeopardize its Medicare certification.”

A potential reimbursement problem with ASC utilization is that ASC payment rates are based on 1986 data and have not been rebased despite frequent proposals to do so. In a March, 2003 report MedPAC stated that ASC payment rates remain adequate. However, the Health and Human Services Office of the Inspector General’s 2004 Work Plan calls for it reexamine whether the rates “are reasonable or need revision,” so there is a chance that the ASC reimbursement picture will improve in the relatively near future.

CORFs

CORFS are a recognized provider of outpatient rehabilitation services reimbursed by Medicare subject to Part B deductible and coinsurance provisions. CORFs provide coverage for a broad array of rehabilitation and medical services furnished on an outpatient basis in a coordinated fashion. These include diagnostic, therapeutic and restorative services. Medicare reimburses CORFS under the Physician Fee Schedule (non-facility rate).

In June of 1998, MedPAC, reconfirmed the government’s support of the CORF Model, stating that CORF is *“an environment offering patients an intensive therapy program while allowing them to live at home. Medicare allows CORF’s to provide a broader array of services and therapy.”*

Providers considering offering orthopedic services in a CORF, should consider that CORFs are *required* to provide three types of services. However these required services fit in well with any orthopedic program:

- Physician Services
- Physical Therapy
- Social or Psychological Services

The first two services are obvious for orthopedic patients. While social or psychological services may not be so obvious, when one considers the psychological adjustments that may be required when coping with an orthopedic injury that requires rehabilitation, visits with a CORF social worker may provide a significant benefit to the patient.

In addition, unlike more limited outpatient venues, CORFs can provide additional services of benefit to orthopedic patients, including:

- Occupational therapy
- Prosthetic and orthotic devices
- Nursing Care
- Supplies, appliances, and equipments
- Single home evaluation visit; and
- Drugs and biologicals (non-self-administered)

Another advantage that CORFs have over other outpatient venues is that the plan of treatment must be reviewed by a physician only every 60 days (as opposed to 30 days in a hospital outpatient setting).

For orthopedic patients, a CORF program can provide an excellent follow-up to home health care, once the patient loses eligibility for home health services. To be eligible to receive reimbursable home health services, a Medicare beneficiary must be homebound which means confined to the home. A beneficiary is considered homebound if he or she has a condition due to an illness or injury that restricts his or her ability to leave his or her place of residence except with:

- (1) the aid of supportive devices, such as crutches, canes, wheelchairs, or walkers;
- (2) the use of special transportation; or
- (3) the assistance of another person, or if leaving home is medically inadvisable.

In addition, leaving home must require a considerable and taxing effort by the beneficiary. Homebound Status for patients of home health agencies has, in recent years, become a particular focus of OIG enforcement. The OIG has stated that is incumbent on home health agencies to “create oversight mechanisms to ensure that the homebound status of a Medicare beneficiary is verified and the specific factors qualifying the patient as homebound are properly documented.”

Thus, once the patient no longer fits the definition of homebound, it is incumbent on the provider to move the patient to an outpatient program. The CORF, with its availability of social and psychological services, is in the ideal position to aid the patient in adjusting to his or her new mobility. CORF staff can aid in this process by pointing out to the patient that, rather than giving up the luxury of home therapy, the patient’s recovery has progressed to the point where he or she no longer requires home care.

Comprehensive Inpatient Rehabilitation Units and Hospitals

CIR units and hospitals provide an appropriate venue for post-operative orthopedic patients who still require inpatient hospital care, but are medically stable and:

- Have rehabilitation potential; and

- Have a medical condition for which Medicare or other payors will reimburse in a CIR setting.

Of all the venues discussed in this article, CIRs are subject to the strictest Medicare conditions of participation. These conditions include the requirement that patient must be able to tolerate three hours of combined therapy per day, that medical necessity must be established for the provision of intensive rehabilitation services, that billing documentation must reflect services actually provided, and that documentation by different disciplines must be consistent with respect to the patient's condition.

The requirement that CIR patients must need and be able to tolerate at least three hours per day of intensive physical and/or occupational therapy is known as the Three Hour Rule. The Three Hour Rule is actually a rule of thumb to establish medical necessity for inpatient rehabilitation, and can be avoided in individual cases, if other factors establish the need for intensive rehabilitation services. Nevertheless, the Three Hour Rule is the touchstone that CMS uses to make an initial finding of medical necessity, and an absence of three hours per day of therapy services in the patient's record will trigger requests for further justification of the CIR stay from fiscal intermediaries.

The Three Hour Rule, however, does not need to be fulfilled by physical or occupational therapy alone. Patients who require inpatient hospital rehabilitation services may need other skilled rehabilitative modalities such as speech language pathology services, or prosthetic-orthotic services. The 3-hour a day requirement can be met by a combination of these other therapeutic services instead of or in addition to physical therapy and/or occupational therapy.

From the perspective of orthopedic services, however, the condition of participation that has proved most controversial for CIR providers is CMS' 75 Percent Rule, which states that 75 percent of the CIR's patients must fall into one of 10 diagnostic groups. These groups are:

- Stroke
- Spinal Cord Injury
- Congenital Deformity
- Amputation
- Major Multiple Trauma
- Fracture of Femur (Hip Fracture)
- Brain Injury
- Polyarthritis, Including Rheumatoid Arthritis
- Neurological Disorders
- Burns

The 75 Percent Rule has been controversial because the most popular orthopedic procedures for inpatient rehabilitation—hip and knee replacements—are not included in the 10 diagnosis groups. The flames of this controversy were fanned in 2003, when CMS proposed a revision of the 75 Percent Rule, which would have continued to exclude joint replacements. However, due to Congressional pressure CMS did not finalize the proposed rule in January 2004 as planned. As of this writing, the original 75 Percent Rule is still in effect, but is not being enforced. At this time, it is unknown what further changes to the 75 percent Rule, if any, CMS will propose.

LTACHs

Long Term Acute Care Hospitals (LTACHs) have become essential to an effective continuum of care as a key venue within a health system. The LTACH is the mirror image of the short term acute care hospital serving patients whose medical conditions require a stay longer than the Medicare prescribed DRG. Unlike CIRs, the Medicare conditions of participation for an LTACH are relatively simple:

- The LTACH must meet any applicable state regulations defining a hospital;
- The LTACH must also meet Medicare Part 482 Federal Regulations defining conditions of participation for hospitals generally;
- Like all other hospitals, the LTACH may choose to meet the JCAHO standards of accreditation for hospitals; and
- The only requirement that is different from any other hospital, the aggregate length of stay for Medicare patients must be greater than 25 days.

For the healthcare system the LTACH provides numerous benefits including extending the continuum of care, diminishing (short term acute hospital) DRG revenue loss, and recognition by managed care payment structures. Unlike CIRs there is no limitation on type of diagnoses that may be admitted to the LTACH and there is also no limitation on patient age or the scope of services provided.

Orthopedic Conditions Appropriate for LTACHS include:

- Medically complex patients;
- Patients requiring re-constructive and extended post surgical care; and
- Patients with rehabilitation related diagnoses that also have complex or tertiary needs.

CMS has established a prospective payment system consisting of 510 LTC-DRGs. The 510 LTC-DRGs are comprised of the DRGs used in the current acute hospital PPS. Unlike their short term acute DRG counterparts, which typically cut off reimbursement Medicare patients after a few days, LTC-DRGs are weighted so as to reimburse the hospital appropriately for patients whose lengths of stay meet the 25-day aggregate required for LTACHs

As a PPS acute care hospital, reimbursement for physician services in an LTACH is identical to that of a PPS short term acute hospital. The physician bills under Part B for Medicare patients or submits bills, in the identical format to short stay acute, for commercial or managed care payors.

In addition to the reimbursement benefit, an LTACH allows the healthcare system to establish a “virtual” rehabilitation program for orthopedic patients who require rehabilitation services, but cannot tolerate three hours of intensive therapy per day. Since the CIR conditions of participation do not apply to the LTACH, the virtual rehabilitation program not only is not subject to the Three Hour Rule, the 75 Percent Rule is inapplicable as well, making the LTACH an ideal venue for orthopedic patients with high comorbidities.

In sum, there are substantial clinical and financial Opportunities for moving orthopedic patients along the continuum of care. ASCs are appropriate for many outpatient orthopedic procedures, while CORFs provide an excellent venue for multidisciplinary outpatient rehabilitation. CIR Units are appropriate for certain orthopedic inpatients with rehab potential, but are subject to significant regulatory limitations. LTACHs, on the other hand, provide appropriate reimbursement for medically complex or high comorbidity orthopedic patients, as well as the opportunity for virtual rehabilitation programs free of CIR regulatory constraints

About the Author:

Cherilyn G. Murer, J.D., C.R.A. is C.E.O. and founder of the Murer Group, a legal-based health care management consulting firm in Joliet, Illinois, specializing in strategic analysis and business development. Ms. Murer may be reached at (815) 727 3355 or via the Web: www.murer.com