

Rehabilitation Reimbursement Update

By:

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Introduction

The Centers for Medicare & Medicaid Services (CMS) and legislators in this country remain dedicated to ensuring that beneficiaries who are severely injured by illness or injury are able to obtain high quality rehabilitative care. At the end of July CMS issued the final inpatient rehabilitation prospective payment system updates stating that, "The rule CMS is adopting today will help to ensure that people with Medicare have access to rehabilitation services that are appropriate to their medical conditions, and that will help them reach their maximum level of recovery as quickly as possible."

Additionally, in July Congress reversed the implementation of the therapy caps for occupational, physical, and speech therapy and instituted a delay until December 31, 2009. Extending the therapy cap exception process helps ensure that Medicare beneficiaries will continue to have access to essential outpatient rehabilitation services provided by physical therapists and physical therapy assistants.

Inpatient Rehabilitation Prospective Payment System Updates

On July 31, 2008 The Centers for Medicare & Medicaid Services (CMS) issued a final rule to improve the accuracy of payment for services furnished to people with Medicare who need the intensive rehabilitation services provided by Inpatient Rehabilitation Facilities (IRFs). These include patients who are recovering from serious illnesses or injuries, such as stroke, spinal cord injuries, severe burns, amputations and a number of other conditions. There are currently more than 1,200 facilities that are paid as IRFs. CMS projects that Medicare payments to IRFs under this final rule will be approximately \$5.6 billion in FY 2009. The IRF Prospective Payment System (PPS) final rule will be effective for discharges on or after October 1, 2008 through September 30, 2009.

As required by the Balanced Budget Act of 1997, CMS implemented an IRF PPS for freestanding IRFs as well as IRF units of a hospital, effective for cost reporting periods beginning on or after January 1, 2002. Since 2002, Medicare has paid rehabilitation hospitals and rehabilitation units in acute care hospitals for inpatient stays under the IRF prospective payment system (PPS). Under this system, patients are classified into case-mix groups (CMGs) taking into account the patient's overall physical and cognitive status. Medicare establishes a weight for each CMG based on the average resources required for treating a patient in that CMG. Medicare makes a single payment to the IRF based on a base rate, which is determined by multiplying the weight for the CMG by a standard federal rate which is updated annually for inflation. The base rate is further adjusted to account for specific characteristics and location of the facility.

In order to be excluded from the acute care hospital PPS and instead be paid the higher rates for providing rehabilitation services under the IRF PPS, a hospital or distinct part unit must first meet the “75 percent rule” or the “compliance percentage threshold.” Today, an IRF must demonstrate that its annual inpatient population consists of at least 60 percent of patients with one or more of the qualifying conditions listed in the table below.

Qualifying Conditions Under the IRF PPS

Patients who have one or more of the following conditions either as the principal reason for receiving treatment in the IRF or as a qualifying comorbidity, and that met certain other conditions, may be counted toward an IRF’s compliance percentage.

1. **Stroke**
2. **Spinal cord injury**
3. **Congenital deformity**
4. **Amputation**
5. **Major multiple trauma**
6. **Fracture of femur (hip fracture)**
7. **Brain injury**
8. **Neurological disorders**
9. **Burns**
10. **Arthritis-related medical conditions (three types specified in the rule)**
11. **Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the IRF stay and one or more of the following criteria are met: (1) it was bilateral, (2) the patient’s BMI was least 50 at the time of admission to the IRF, or (3) the patient was 85 or older at the time of admission to the IRF.**

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This compliance rate was scheduled to increase to 75 percent for cost reporting periods beginning on or after July 1, 2008. However, provisions in the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) required CMS to set the compliance rate no higher than the 60 percent compliance rate that became effective for cost reporting periods beginning on or after July 1, 2006. Further, the statutory provisions also required CMS to continue the use of comorbidities (that is, patient specific conditions that are secondary to the patient’s principal diagnosis) in addition to the patient’s primary reason for being in the IRF in determining the IRF’s compliance percentage under this rule.

The payment rates set by the IRF PPS for rehabilitation therapy services are higher than would be paid for services in other settings, such as hospital outpatient

departments, skilled nursing facilities, or home health. Congress and CMS reasoned patients in an IRF have more severe and more complex medical conditions that need more intensive and coordinated rehabilitation services.

As part of its ongoing effort to transform Medicare into a prudent purchaser of quality health care services and improve the accuracy of its payment systems, CMS has recalculated the weights assigned to the CMGs using more recent data from rehabilitation hospitals about the types of patients they are treating and the resources required. However, as required by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), the final rule sets the inflation update for the standard federal rate at zero percent for FY 2009.

Changes to the IRF PPS for FY 2009

- **CMG Relative Weights:** CMS is updating the CMG relative weights and average length of stay values using FY 2007 IRF claims data and FY 2006 IRF cost report data. The current CMG relative weights, which have been used to set payment rates since FY 2006, are based on FY 2003 data and do not reflect the impact on case mix of the revised 60 percent rule criteria.
- **High-Cost Outlier Threshold:** CMS is setting the outlier threshold for FY 2009 at \$10,250, the amount estimated to maintain estimated outlier payments equal to 3.0 percent of total estimated payments for FY 2009.
- **Wage Index Adjustment:** CMS is continuing to use the pre-reclassified and pre-floor hospital wage indexes to determine the FY 2009 rates. For the purposes of this final rule, CMS is using the final FY 2008 pre-reclassified and pre-floor hospital wage indexes.
- **Implementation of IRF PPS Provisions in the MMSEA:** CMS is implementing the statutory provisions by setting the compliance percentage at 60 percent for cost reporting periods beginning on or after July 1, 2006, and by continuing to count comorbidities under specified conditions when determining an IRF's compliance with the threshold. CMS is also updating the IRF PPS payment rates by zero percent for FY 2009, in compliance with the statute which sets the increase factor for IRFs at zero percent for FYs 2008 and 2009, effective for discharges beginning on or after April 1, 2008.
- **Payment Rate Impact Analysis:** The changes will result in an estimated decrease in aggregate IRF payments of \$40 million, or 0.7 percent of total IRF payments, for FY 2009. This decrease is due to the update to the outlier threshold amount to maintain estimated outlier payments at 3.0 percent for FY 2009.

Therapy Cap Relief

For the past decade, there has been a proposed cap on payment for Medicare services for occupational, physical, and speech therapy. Throughout the years, trade associations have been fighting the implementation of these rules, as they would directly impact the ability to provide services to patients. A cap means a limitation in terms of the dollars paid, but by default this also means a limitation on the services provided. A series of extensions or exceptions have been passed by Congress to delay the implementation of the therapy caps.

July 1, 2008 was a watermark date in the history of these rule changes and was the date the therapy cap extensions were set to expire. On June 24, 2008, the House of Representatives overwhelmingly passed a bill to delay the process yet another time (HR 6331). The vote was 355-49. The Senate did not approve HR 6331 until July 9th. Therefore, on July 1, 2008 the therapy caps were fully implemented. On July 10, 2008 the House and Senate sent the legislation to the White House to be enacted into law on July 10, 2008. However, President Bush vetoed the bill on July 15, 2008.

On July 15, 2008, the United States House of Representatives and the Senate voted to override the Presidential veto to pass HR 6331 – The Medicare Improvements for Patients and Providers Act. HR 6331 includes critical provisions for physical therapists and their patients, including legislation to avoid the 10.6% cut in payments under the Medicare physician fee schedule and the expiration of the therapy cap exceptions process. The therapy caps were delayed again until December 31, 2009.

Outpatient therapy service providers may now resume submitting claims with the KX modifier for therapy services that exceed the cap furnished on or after July 1, 2008. For physical therapy and speech language pathology services combined, the limit on incurred expenses is \$1810 for calendar year 2008. For occupational therapy services, the limit is \$1810. Deductible and coinsurance amounts applied to therapy services count toward the amount accrued before a cap is reached. Services that meet the exceptions criteria and report the KX modifier will be paid beyond this limit.

Before this legislation was enacted, outpatient therapy service providers were previously instructed to not submit the KX modifier on claims for services furnished on or after July 1, 2008. The extension of the therapy cap exceptions is retroactive to July 1, 2008. As a result, providers may have already submitted some claims without the KX modifier that would qualify for an exception.

Providers submitting these claims using the 837 institutional electronic claim format or the UB-04 paper claim format would have had these claims rejected for exceeding the cap. These providers should resubmit these claims appending the KX modifier so they may now be processed and paid. Providers submitting these claims using the 837 professional electronic claim format or the CMS-1500 paper claim format would have had these claims denied for exceeding the cap. These providers should request to have their claims adjusted in order to have the contractor pay the claim. In all cases, if the beneficiary was notified of their liability and the beneficiary made payment for

services that now qualify for exceptions, any such payments should be refunded to the beneficiary.

Conclusion

While there is an overall 0.7% payment decrease for FY 2009 inpatient rehabilitation facilities, the reinstatement of the therapy cap exceptions and delay of full implementation of the compliance threshold are high notes in the world of rehabilitation. CMS and legislators across the country remain dedicated to ensuring that Medicare beneficiaries in dire need of rehab services, such as those who have had a stroke or amputation or who have experienced a traumatic brain injury or multiple trauma, continue to have full and timely access to critical rehabilitation services.

About the Author:

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