

Rehab's Resurgence

By

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In the waning hours of its 2005 session, Congress delivered two key pieces of rehabilitation legislation, one each for inpatient and outpatient providers. Although neither act gives the provider community everything it hoped for, the legislation does signal a resurgence in Congressional awareness of the effect both its laws and CMS' regulations have on rehabilitation providers, and it offers hope that more thorough Congressional action is in the offing. Both pieces of legislation are contained in the Deficit Reduction Omnibus Reconciliation Act of 2005, which the House is expected to finalize when it returns from its winter break. On the inpatient side, the Act provides breathing space for hospitals and rehab units struggling to comply with CMS' mandated percentages under the 75 percent rule. For outpatient providers, the Act promises at least some relief from the therapy caps that are set to go back into effect on January 1, 2006.

75 Percent Rule Extension

In several past articles we have discussed the tug-of-war between CMS and the inpatient rehabilitation provider community over the implementation of CMS's recent revisions to the "75 percent rule." As finally modified in 2004, the 75 percent rule requires that a specified percentage of any inpatient rehabilitation facility's (either rehabilitation hospital or distinct part rehabilitation unit of a hospital) patients require treatment for one or more of the following conditions:

- Stroke;
- Spinal cord injury;
- Congenital deformity;
- Amputation;
- Major multiple trauma;
- Hip fracture;
- Brain injury;
- Polyarthritis including rheumatoid arthritis;
- Neurological disorders, including multiple sclerosis, motor neuron diseases, Polyneuropathy, muscular dystrophy, and Parkinson's disease;
- Burns;
- Active polyarticular rheumatoid arthritis; psoriatic arthritis, and seronegative arthropathies;
- Systematic vasulidities with joint inflammation; and
- Severe or advanced osteoarthritis involving two or more major weight bearing joints.

In addition, the three arthritis categories require that the condition has not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

The 75 percent rule also counts hip or knee replacements as qualifying conditions if one of the following three conditions is satisfied:

1. The patient underwent a bilateral hip or knee replacement during an inpatient hospital stay immediately preceding the IRF admission;
2. The patient is extremely obese, with a Body Mass Index of at least 50 at the time of admission to the IRF; or
3. The patient is age 85 or older at the time of admission to the IRF.

As the name, “75 percent rule” suggests, the required percentage of patients that must require treatment for a compliant condition has traditionally been 75 percent. However, to allow providers time to adjust their admission practices and patterns to conform to the modified rule, CMS instituted the following phase in schedule of required compliance percentages:

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, providers are allowed to count secondary medical conditions (comorbidities) toward the required percentages. The ability to count comorbidities as compliant conditions, however, is time limited. For cost reporting periods beginning on or after July 1, 2007, comorbidities may not be used in counting a patient as compliant.

As the first mandated level of 50 percent began taking effect in July of 2004, many inpatient providers, while generally able to cope with the 50 percent level, began to view the increased compliance levels mandated for subsequent years as unobtainable. As a result, the provider community began lobbying Congress to freeze mandated compliance at 50 percent. Congress, however, eventually decided on holding the mandated minimum at 60 percent for additional year. As a result, the mandated percentages going forward are now:

1. 60 percent for cost reporting periods beginning on or after July 1, 2005 and before July 1, 2007;

2. 65 percent for cost reporting periods beginning on or after July 1, 2007 and before July 1, 2008; and
3. 75 percent for cost reporting periods beginning on or after July 1, 2008.

The legislation did not contain language addressing the use of comorbidities to determine compliance, so the prohibition of using comorbidities to determine compliance for cost reporting periods beginning on or after July 1, 2007 remains unchanged.

Although this extension falls a bit short of what the providers' lobbyists had hoped for, the additional year at the lower compliance levels does give providers additional breathing space in which to adjust their product lines to comply with the new rule.

The Therapy Caps Return – With an Escape Hatch

Readers familiar with Medicare reimbursement for outpatient physical therapy, speech language pathology and occupational therapy know that since 1999 the Medicare statute has contained a dollar amount cap on each Medicare patient's benefits for those therapies. However, those readers also know that, except for a brief period in late 2003, Congress has continuously suspended enforcement of those caps. With Congress' latest action, however, 2006 will be somewhat of an exception.

Nominally, at least, Congress has declined to continue the suspension of enforcement of the caps. As a result, effective January 1, 2006, there will be two separate annual caps on outpatient therapy services. One \$ 1,740 cap will apply in combination to physical therapy and speech language pathology. A separate \$ 1,740 cap will apply to occupational therapy. The caps will apply to services provided by physician office clinics, freestanding therapy practices, rehabilitation agencies, and CORFs. The caps, however, will not apply to outpatient departments of hospitals.

On November 18, 2005, CMS issued instructions to its contracting carriers and fiscal intermediaries for capturing and enforcing the benefit limits. However, in the Deficit Reduction Act, Congress enacted a provision under which the patient "or a person acting on behalf" of the patient may request an "exception" from the cap limit as "medically necessary." The legislation gives CMS 10 business days in which to respond to the request for an exception. If CMS does not respond within the 10 business days, the exception is deemed medically necessary.

The legislation, however, provides no additional guidance to CMS or its carriers and fiscal intermediaries as to how to go about implementing the exceptions. It also does not provide any standards by which CMS is to determine the medical necessity of the exception. As of this writing, CMS has given no indication as to how it will go about implementing the exception, or what effect, if any, the new legislation will have on its directive for implementing the caps.

It is a fair assumption that the new legislation will cause at least some interruption in the

cap enforcement process while CMS endeavors to implement the new exception requirement. Furthermore, while the precise process that CMS will choose for that implementation cannot be known at this time, it is noteworthy that the legislation specifically states that persons acting on the patient's behalf may apply for the exception. Presumably this language will allow providers to submit the exception request for their patients. By including appropriate documentation of medical necessity with the request, providers may be able to assist their patients who require their services in avoiding the harshest effects of the caps.

In the meantime, of course, the provider community is pressing ahead with its efforts to convince Congress to permanently repeal the caps. Congressional support for such a repeal has always been strong, and, hopefully, during the period of adjustment to the caps and the new exception, Congress will finally take more definitive action.

Conclusion: Reason for Optimism

Although these two pieces of legislation may not contain everything the rehabilitation provider community has hoped for, there is reason for optimism. The extension of the lower compliance percentages for the 75 percent rule should allow CMS and the provider community time to develop more up-to-date criteria for defining an inpatient rehabilitation facility without forcing a large number of providers to face the unpleasant prospect of decertification. For outpatient providers, the new exception should give them an opportunity to continue to serve their patients in an appropriate manner while efforts to permanently repeal the caps continue.

About the Author:

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