

REHAB RULES REVISITED

by

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Recent changes in the rules governing inpatient rehabilitation hospitals and units, particularly the implementation of the new prospective payment system for inpatient rehabilitation facilities (IRF PPS) on January 1, 2002,¹ and CMS's poorly understood actions regarding enforcement of the 75 percent rule may have created the impression that there have been major changes to the Medicare compliance requirements for inpatient rehabilitation service providers. In fact, the opposite is true. The key requirements for hospitals and units that are exempt from the acute care hospital PPS remain firmly in place. This article will examine how four of these requirements—the 75 percent rule, the three hour rule, the twenty-hours per week requirement for unit medical directors, and the “DRG year” for converted rehabilitation unit beds, remain cornerstone requirements for inpatient rehabilitation providers.

The 75 Percent Rule

Since its implementation in 1983, the inpatient acute care hospital PPS has exempted from its provisions freestanding rehabilitation hospitals and inpatient rehabilitation units of general hospitals that meet certain criteria. One these criteria is that 75 percent of the exempt hospital's or unit's patients, during its most recent twelve-month cost reporting period, must have a diagnosis that falls into one or more of ten specific categories. These ten categories, which have not changed since the rule was first created in 1984, are:

- Stroke
- Spinal cord injury
- Congenital deformity
- Amputation
- Major multiple trauma
- Fracture of femur (hip fracture)
- Brain injury
- Polyarthritis, including rheumatoid arthritis
- Neurological disorders, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease
- Burns²

In recent years, rehabilitation providers have complained that the 75 percent rule's ten diagnosis categories are becoming increasingly irrelevant to today's

¹ 42 C.F.R. §§ 412.600 – 412.632.

² 42 C.F.R. §§ 412.23(b)(2), 412.29(a), 412.30(b),(c).

rehabilitation patient population. In a joint open letter to Tommy Thompson, the Secretary of the Department of Human Services, the American Medical Rehabilitation Providers Association, the American Academy of Neurology, the American Academy of Physical Medicine and Rehabilitation (AAPM&R), the American Hospital Association, and the Federation of American Hospitals, pointed out that data collected by CMS's IRF PPS contractor indicate that only 50 percent of the patients presenting at inpatient rehabilitation facilities were treated for a condition that fell into one or more of the ten categories. The issue came to a head early in 2002 when several inpatient rehabilitation facilities in New Jersey and Tennessee were issued notices of non-compliance by their fiscal intermediaries after audits of their admission diagnosis categories.

The organizations who wrote the open letter to Secretary Thompson suggested that CMS adopt an administrative presumption whereby, if 75 percent of the hospital's or unit's Medicare patients fall in 20 of the 21 Rehabilitation Impairment Categories (RIC) used to classify patients into a Case-Mix Group (CMG) for the IRF PPS, then the facility would be presumed to comply with the 75 percent rule. They also urged that CMS place a moratorium on qualifying 75 percent rule audits by the fiscal intermediaries.

When CMS Administrator Thomas A. Scully issued a reply to the open letter on May 23, 2002, stating that CMS has undertaken a comprehensive review of the 75 percent rule, many in the provider community hastened to declare victory. For example, the AAPM&R web site reported that,

“CMS will not enforce the “75 percent rule” for rehabilitation facilities while it closely examines current application of the rule. . . . There is concern that the policy is not evenly applied and that the rule will not be enforced until CMS has conducted an in-depth investigation. No funds will be recouped retrospectively. . . . Tom Scully, CMS Administrator, has encouraged rehab providers to continue to monitor their adherence to the current 10 diagnostic categories. CMS plans to instruct regional fiscal intermediaries that no enforcement activity should be undertaken.”

Unfortunately, this is not quite an accurate account of what Administrator Scully's letter says. The letter states that, “we have instructed the FIs not to take any actions as a result of their reviews until we have been able to assess the situation fully.” It does *not* state the FIs should not continue to conduct qualifying 75 percent audits, nor does it state that funds will not be recouped retroactively. Furthermore, the CMS website continues to state that the “RICs and CMGs used to determine payment under the IRF PPS will not be used to determine if the IRF meets the 75 percent rule.”

Thus, the 75 percent rule in its original form, based on the original ten diagnosis categories, remains a qualifying requirement for inpatient rehabilitation facilities. We can hope that CMS's review will lead to constructive changes in the rule, but

for the present, facilities should still do everything in their power to comply with the rule as written.

The 3 Hour Rule

Unlike the 75 percent rule, the “3 hour rule” is not, strictly speaking, a rule at all. The 3 hour rule is not specified in any regulation, and, therefore, it does not have the force of law.³ Nevertheless, CMS’s viewpoint, that the “general threshold for establishing the need for inpatient hospital rehabilitation services is that the patient must require and receive at least 3 hours a day of physical and/or occupational therapy,”⁴ has achieved such general acceptance that it has become a virtually unquestioned part of the rehabilitation services culture. For example the AAPM&R letter to Secretary Thompson that urged fundamental changes to the 75 percent rule, simply states that “[o]ver time, ‘intensive rehabilitation services’ has come to mean at least three hours of therapy a day.”

CMS’s guidance on the 3 hour rule notes that the daily component of the rule may be satisfied by furnishing therapy services five days a week.⁵ Also, while most patients will satisfy the 3 hour rule through physical or occupation therapy, CMS recognizes that other therapies, such as speech-language pathology services, or prosthetic-orthotic services may be required. In such cases, the 3 hour rule may be satisfied by the furnishing of such services instead of or in addition to physical therapy or occupational therapy.⁶ Furthermore, if the patient has a secondary diagnosis or medical complication that rules out 3 hours of therapy a day, inpatient hospital care may nevertheless be the only reasonable means by which even a low intensity rehabilitation program can be safely carried out. However, in such cases, CMS requires documentation justifying the existence and extent of the complicating conditions that affect the carrying out of a rehabilitation program.⁷

Thus, while the 3 hour rule is the touchstone for evaluating a patient’s need for inpatient rehabilitation services, there is no “irrebuttable presumption of noncoverage” when a patient fails to meet that standard.⁸ Instead, as a federal court noted in an agreed order between CMS and a rehabilitation provider, the 3 hour rule should be used as a claims-screening criterion. For example, a peer review organization should use the 3 hour rule to determine which claims may be *allowed* at the initial review level. Failure to satisfy the 3 hour standard should not mean automatic denial of the claims. Instead the PRO should refer the case to a physician reviewer for a determination of medical necessity.⁹

³ *Hooper v. Sullivan*, CCH Medicare & Medicaid Guide ¶ 37,985 (D. Conn. 1989).

⁴ CMS Intermediary Manual § 3101.11.

⁵ *Id.*

⁶ *Id.*

⁷ *Id.*

⁸ *Hooper v. Sullivan*, CCH Medicare & Medicaid Guide ¶ 37,985 (D. Conn. 1989).

⁹ *Id.*

Another federal court has recently emphasized the flexibility built into the 3 hour rule by refusing to adopt it as a standard in civil law suits brought under the False Claims Act. In rejecting the whistleblower's argument that the facility had filed false claims because several of its patients did not satisfy the 3 hour rule, the court stated, "We decline to adopt the rigid and unsupported definition of "intensive rehabilitative services" contained within the Complaint. Indeed . . . plaintiff acknowledges that "intensive rehabilitative services is not defined in Medicare statutes and regulations." ¹⁰

The 20 Hours Per Week Rule for Unit Medical Directors

Documenting the hours worked by the medical director of a rehabilitation hospital presents few problems for providers, because the regulations require that the director work full-time for the hospital. ¹¹ For inpatient rehabilitation units, however the problem can be somewhat thorny because the regulations state that the medical director must provide "services to the unit and to its inpatients for at least 20 hours per week." ¹²

The documentation problem often arises when the unit provides services to both inpatients and outpatients. Recognizing that it would be impractical to require the medical director of such a unit to attempt to divide time spent on administrative functions between the inpatient and outpatient aspects of the unit's program, CMS permits the medical director to count all administrative time toward satisfaction of the 20 hour requirement. ¹³ The medical director, however, may allocate to the 20 hour requirement only that portion of time spent furnishing direct patient care that was actually spent treating inpatients. ¹⁴ Thus, it is critically important for the medical director to keep accurate logs of the time spent working for the unit and its patients.

Accurate medical director logs are critical to the hospital from a reimbursement as well as a compliance viewpoint. The regulations provide that physician compensation costs cannot be reimbursed to the hospital unless the physician's time records are maintained "in a form that permits the information to be validated by the intermediary." ¹⁵ CMS's publications and administrative decisions make it clear that a daily log with readily verifiable information is the strongly preferred method for maintaining the physician's time records. The CMS Provider Reimbursement Manual states that, "While we do not require the maintenance of *daily* logs or time records to support provider services rendered by physicians, adequate documentation must be maintained to support the total hours for these

¹⁰ *U.S. ex rel. Mathews v. Healthsouth Corp.* 140 F.Supp.2d 706, 711 (W.D. La. 2001).

¹¹ 42 C.F.R. § 412.23(b)(5).

¹² 42 C.F.R. § 482.29(f)(1).

¹³ CMS Provider Reimbursement Manual, Part 1, § 3001.7D.

¹⁴ *Id.*

¹⁵ 42 C.F.R. § 415.60(g)(1).

services.”¹⁶ Although a daily log may not, strictly speaking, be an absolute requirement, CMS has emphasized that daily time records are the preferred method of verifying physician hours.¹⁷

The DRG Year for Converted Beds

When a hospital adds a new rehabilitation unit or expands an existing rehabilitation unit with beds that qualify as new beds, providing all the other conditions of participation are met, it may begin treating and billing for the new unit or new beds as exempt from the acute care PPS beginning with the first full cost reporting period during which the rehabilitation services are provided.¹⁸ Hospitals that have not previously participated in the Medicare program may self certify as exempt for any cost reporting period of not less than one month and not more than eleven months occurring between the date that the hospital began participating in Medicare and the start of its regular cost reporting period.¹⁹

However, if the hospital increases the rehabilitation unit size by converting existing beds, it must demonstrate to the fiscal intermediary that “for all of the hospital’s most recent cost reporting period of at least 12 months, the beds have been used to treat an inpatient population meeting the requirements of [the 75 percent rule].”²⁰ Thus, for a full year prior to being able to bill for the converted beds as exempt beds, the hospital is required to bill for the beds at the DRG rate under the acute care PPS, even though the beds are occupied by otherwise qualified rehabilitation patients. It is hardly surprising, therefore, that the record is replete with cases in which hospitals have strenuously fought the fiscal intermediary’s decision to classify rehabilitation beds as converted rather than new.

The converted beds rule, like the 75 percent rule, the 3 hour rule, and the 20 hours per week rule for unit medical directors, demonstrates that, despite all that is new in the inpatient rehabilitation billing arena, the rules of compliance that were established at the beginning of the Medicare program for exempt rehabilitation hospitals and units remain very much in force.

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¹⁶ CMS Provider Reimbursement Manual § 2182.3C4.

¹⁷ *Methodist Hospital (St. Louis Park, Minn.) v. Blue Cross and Blue Shield of Minnesota* (Administrator Decision, Dec. 29, 1997).

¹⁸ 42 C.F.R. § 412.30(b)(3).

¹⁹ 42 C.F.R. § 412.30(b)(4).

²⁰ 42 C.F.R. § 412.30(d)(2)(ii).