

Proposed Updates to IRF and SNF Reimbursement for Fiscal Year 2010

By:
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Introduction

In early May, the Centers for Medicare and Medicaid Services (CMS) issued its proposed rules for the Skilled Nursing Facility (released May 1st) and Inpatient Rehabilitation Facility (released May 6th) prospective payment systems. Both sets of proposed rules will create some substantive changes for inpatient rehabilitation and skilled nursing facilities across the country. While skilled nursing facilities should expect an estimated \$390 million decrease in payments, inpatient rehabilitation facilities should see an increase of approximately \$150 million.

Additionally, there will be numerous changes that will impact therapy provision and management starting on October 1, 2010 for skilled nursing facilities in the form of revisions to the current RUGs hierarchy and rate changes. CMS is also proposing the most dramatic changes to the IRF-PPS since it adopted changes to the IRF “75 percent rule” criteria for cost reporting periods beginning on or after July 1, 2004. Specifically, the rule would impose extensive preadmission screening requirements, increase the responsibilities of physicians, require additional face-to-face encounters with patients, mandate that physicians and nurses have specialized training in rehabilitation, revise the post admission evaluation process, and require IRFs to create and maintain additional documents in the patient medical record, in addition to other obligations.

Proposed Inpatient Rehabilitation Facility Updates

On May 6, 2009, CMS published its proposed IRF PPS update for FY 2010. For FY 2010, CMS proposes to apply a 2.4% market basket increase, which is estimated to increase payments under IRF-PPS by \$140 million. This payment update is based on the Rehabilitation, Psychiatric, and Long-term Care (RPL) market basket and if finalized as proposed, the market basket update would increase total payments to IRFs in FY 2010 by \$140 million. The proposed rule would also increase the outlier threshold amount for FY 2010 to \$9,976, resulting in an additional \$10 million increase in aggregate IRF-PPS payments. Thus, the total increase in IRF payments under this proposed rule is \$150 million.

In addition to updating the payment methodology, CMS has proposed dramatic changes to patient selection and care provisions of the IRF PPS rule. CMS Acting Administrator Charlene Frizzera stated, “CMS is proposed updates to the current IRF coverage criteria that would better reflect industry-wide best practices, and improve understanding and consistency of medical necessity guidelines.”

In the proposed rule CMS states that it has become apparent that the existing IRF payment requirements and instructions do not always enable facilities to distinguish between patients who require complex, high intensity rehab care in a hospital environment and those patients whose rehab needs can be met in less intensive settings. As a result, different and sometimes conflicting interpretations of IRF medical necessity arise, leading to a high volume of IRF claim denials and ultimately concerns about the effects these denials have on access to IRF care.

The Proposed Rule seeks to clarify and revise existing requirements for pre-admission screening, post-admission evaluations, and individualized treatment planning. *The following chart provides a summary of the proposed revisions in each of these areas:*

<p>Pre-Admission Requirements</p>	<ul style="list-style-type: none"> • IRF shall ensure that each patient's treatment is managed using a coordinated "interdisciplinary" approach to treatment, not just "multidisciplinary." • Expand scope of preadmission assessment to require documentation of the clinical evaluation process that must form the basis of the admission decision. • Comprehensive preadmission screening must include an evaluation of the following requirements that a patient must meet to be admitted to an IRF: <ol style="list-style-type: none"> 1. Patient be sufficiently stable at time of admission to allow patient to actively participate in an intensive rehabilitation program; 2. At the time of admission, the patient must required the active and ongoing therapeutic intervention of at least two therapy disciplines, one of which must be PT or OT; and 3. Patients generally must require and reasonably be expected to actively participate in at least 3 hours of therapy per day at least 5 days per week and be expected to make measureable improvement that will be of practical value to improve patient's functional capacity or adaptation to impairments. The therapy treatment must begin within 36 hours after patient's admission. • An evaluation of each patient's risk for clinical complications is a mandatory part of preadmission screening. • Close medical supervision requirement met by having a rehab physician, or other licensed treating physician, conduct face-to-face visits with the patient a minimum of at least 3 days per week throughout patient's stay. • Preadmission screening must be conducted by a qualified clinician(s) designated by a rehab physician within 48 hours immediately preceding the IRF admission. • Preadmission screening documentation must be retained in patient's medical record. • A rehabilitation physician must review and document his or her concurrence with the findings and results of the preadmission screening. • Delete the current post-admission evaluation period.
<p>Post-Admission Requirements</p>	<ul style="list-style-type: none"> • Add requirement for a post-admission evaluation by a rehabilitation physician within 24 hours of admission in order to document the patient's status on admission to the IRF, compare it to that noted in preadmission screening documentation, and begin development of the patient's expected course of treatment that will be completed with input from all of the interdisciplinary team members in the overall plan of care. • Require that an individualized overall plan of care be developed for each IRF admission by a rehabilitation physician within input from the interdisciplinary team within 72 hours of the patient's admission to the IRF, and retain this plan in the patient's medical record.
<p>Interdisciplinary Team Meeting Requirements</p>	<ul style="list-style-type: none"> • Increase the required frequency of the interdisciplinary team meeting to at least once per week rather than at least once every two weeks. • Broaden the requirements regarding the professional staff that are expected to participate in the interdisciplinary team meetings by mandating professionals from the following disciplines: <ul style="list-style-type: none"> ○ A rehabilitation physician with specialized training and experience in rehabilitation services; ○ A registered nurse with specialization or experience in rehabilitation ○ A social worker or case manager (or both); and ○ A licensed or certified therapist from each therapy discipline involved in treating the patient. • Require that the rehabilitation physician document concurrence with all decisions made by the interdisciplinary team at each meeting. <p style="text-align: right;">© Murer Consultants, Inc.</p>

Proposed Skilled Nursing Facility Updates

In the Skilled Nursing PPS Proposed Rule, CMS is again proposing a controversial provision that was considered but not adopted for FY 2009. The proposal would recalibrate case mix weights to compensate for increased expenditures resulting from refinements made in 2006. The recalibration would reduce overall SNF PPS payments by 3.3% (\$1.050 billion) in FY 2010. This decrease would be partially offset by a 2.1% market basket update (a \$660 million increase), resulting in the 1.2% negative update. Thus, should the proposed rule be adopted unchanged, the net loss in payments to SNFs is estimated to be \$390 million for FY 2010.

In addition to updating the SNF PPS, the Proposed Rule also:

- Proposes a revised case mix classification methodology (RUG-IV) and implementation schedule for FY 2011, reflecting updated staff time measurement data derived from the Staff Time and Resource Intensity Verification (STRIVE) project;
- Invites comment on a possible new rate component to account for the use of non-therapy ancillaries (as recommended by MedPAC);
- Includes information on the transition to the Minimum Data Set, Version 3.0 (MDS 3.0) redesigning nursing home resident assessment instrument, including an implementation schedule; and
- Invites comment on a possible new requirement for the quarterly reporting of nursing home staffing data.

With the introduction of RUGs-IV, CMS proposes to modify the eight levels of the current RUGs hierarchy by increasing the number of case-mix groups from 53 to 66. There will be an impact on the services and conditions that qualify patients into a particular category. In RUG-IV, CMS is proposing to maintain the existing RUG-III rehabilitation category descriptions as well as existing subcategories and criteria. In other words, rehabilitation level categorization will continue to be based on the same time, day, and discipline criteria from previous years.

Additionally, rates changes are proposed that involve calculating rates using ratios that are based on staff time and wage levels. It appears that in this proposed rule, nursing services are valued higher than previous RUG-III levels and therapy services are valued lower. The wage data used to calculate these ratios is from 2006 and may not be accurate relative to the current market. CMS estimates a reduction in payments for the therapy components of 38 percent for free-standing SNFs and 20 percent for hospital-based SNFs.

Conclusion

In today's tumultuous times, healthcare providers must navigate the waters with neither pessimism nor fear; but with a strong dose of practicality and pragmatism. Medical necessity, while always an important consideration for appropriateness of venue, is more critical now than ever with the RAC audits and other medical necessity reviews in place. It is imperative for inpatient rehabilitation facility providers to ensure the new mandates are met to guarantee full payment of claims.

Additionally, skilled nursing facilities must be prepared to manage against the proposed decreased reimbursement. We should all remain committed to achieving full compliance with all new regulations as well as financial management during these tumultuous times. Healthcare reform efforts will continue to transform the backdrop for IRF and SNF providers and now is the time for providers to prepare for change through practical planning and defined strategy.

About the Author:

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