



WISCONSIN HOSPITAL ASSOCIATION, INC.

**Summary of Final Rule**

**on**

**Medicare Program: Changes to the Criteria**

**for Being Classified as an**

**Inpatient Rehabilitation Facility**

**May 13, 2004**

## **BACKGROUND**

The Social Security Act gives the Secretary of Health and Human Services the discretion to define a rehabilitation hospital and unit. The “75% rule” is one of the criteria that an inpatient rehabilitation facility (IRF) must meet. This criteria requires that 75% of an IRF’s patients must require intensive rehabilitation services to treat one of a specified list of conditions. This final rule responds to public comments on the September 9, 2003 proposed rule and revises the criteria that are used to classify a hospital as an IRF. This final rule also modifies and expands the medical conditions listed in the regulatory requirements and temporarily lowers the percentage of patients required to fall within one of the specified list of medical conditions.

## **FINAL RULE PROVISIONS**

### **Compliance Transition**

The final rule indicates that providers’ compliance with the revised 75% rule will begin at 50% and progress to 75% as outlined below:

- Beginning with cost reporting periods beginning on or after July 1, 2004, and before July 1, 2005, the compliance threshold will be 50% of the IRF’s total patient population.
- Beginning with cost reporting periods beginning on or after July 1, 2005, and before July 1, 2006, the compliance threshold will be 60% of the IRF’s total patient population.
- Beginning with cost reporting periods beginning on or after July 1, 2006 and before July 1, 2007, the compliance threshold will be 65% of the IRF’s total patient population.
- Beginning with cost reporting periods beginning on or after July 1, 2007, the compliance threshold will be 75% of the IRF’s total patient population.

In addition, the provision to count a comorbidity toward the compliance threshold will expire for cost reporting periods beginning on or after July 1, 2007 (see “Use of Comorbidities” below).

### **Administrative Presumption of Compliance**

The Centers for Medicare and Medicaid Services (CMS) will instruct the fiscal intermediaries (FIs) that if, in most cases, an IRF’s Medicare population meets the compliance threshold, the FI should administratively presume that the facility’s total patient population meets the compliance threshold. If an IRF’s Medicare population does not meet the compliance threshold, CMS will instruct the FI to specifically calculate if the IRF’s total patient population met the compliance threshold. As stated in the September 9, 2003 proposed rule, CMS expects individual IRFs to notify their FIs if they believe that their Medicare population is not wholly representative of the total facility patient population.

### **Period to Determine Compliance**

Current regulations require that data from “the most recent 12-month cost reporting period” be used to determine compliance with the 75% rule. CMS will instruct fiscal intermediaries (FIs) to

begin testing compliance with cost report periods beginning on or after July 1. CMS has acknowledged that FIs should not use data for patients admitted before July 1. CMS has determined that FIs and the CMS regional office need at least four months to collect patient data and make compliance determinations before changing the classification of a hospital. Therefore, CMS has established the following schedule for implementing the compliance test.

<b>For Cost Reporting Periods Beginning On:</b>	<b>Review Period: (Admissions During)</b>	<b>Number of Months in Review Period</b>	<b>Compliance Determination Applies to Cost Reporting Period Beginning On:</b>
7/1/2004	07/01/2004-02/28/2005	8	7/1/2005
8/1/2004	07/01/2004-03/31/2005	9	8/1/2005
9/1/2004	07/01/2004-04/30/2005	10	9/1/2005
10/1/2004	07/01/2004-05/31/2005	11	10/1/2005
11/1/2004	07/01/2004-06/30/2005	12	11/1/2005
12/1/2004	08/01/2004-07/31/2005	12	12/1/2005
1/1/2005	09/01/2004-08/31/2005	12	1/1/2006
2/1/2005	10/01/2004-09/30/2005	12	2/1/2006
3/1/2005	11/01/2004-10/31/2005	12	3/1/2006
4/1/2005	12/01/2004-11/30/2005	12	4/1/2006
5/1/2005	01/01/2005-12/31/2005	12	5/1/2006
6/1/2005	02/01/2005-01/31/2006	12	6/1/2006
7/1/2005	03/01/2005-02/28/2006	12	7/1/2006

For example, an IRF whose first cost report under the 75% rule begins on January 1, 2005 will be tested using data for patients admitted from September 1, 2004 through August 31, 2005. Per the four-year phase-in of the rule, initially 50% compliance is required; therefore, if less than 50% of these patients required treatment for one of the specified conditions, the facility would lose its IRF classification for the cost reporting period beginning on January 1, 2006. CMS will not recoup payments made during the 2005 cost report period.

If a facility loses its classification and wishes to reapply to become an IRF in a subsequent cost reporting period, the IRF is instructed to contact its FI and CMS regional office before the beginning of that affected cost reporting period. The FI and regional office would tell the IRF what the most recent, consecutive, and appropriate 12-month period would be, to be used as the review period.

**Medical Conditions - §412.23(b)(2)**

The original compliance test required that at least 75% of an IRF's patients receive intensive rehabilitation services for treatment of one of the following ten conditions:

- 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; and
- burns.

**Polyarthritis**—In this final rule, CMS has removed the medical condition “polyarthritis, including rheumatoid arthritis”.

**Added Conditions**—CMS has added the following four groups of arthritis-related conditions it deems appropriate for intense, inpatient rehabilitation, making a total of 13 conditions included as part of the 75% rule.

***1.) Active, Polyarticular Rheumatoid Arthritis, Psoriaticarthritis, and Seronegative Arthropathies; and***

***2.) Systemic Vasculidities with Joint Inflammation***

CMS expects that each of these conditions have resulted in a patient’s significant functional impairment of ambulation and other activities of daily living, which 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 which results from a systemic disease activation immediately before admission, but has the potential to improve with more intensive rehabilitation.

***3.) Severe/Advanced Osteoarthritis***

CMS has amended the standard for osteoarthritis and now considers this as meeting the compliance threshold if a patient has two major, weight-bearing joints (that is, shoulders, elbows, hips, and knees) with severe or advanced osteoarthritis (but not including any replaced joints). The final rule stipulates that this condition is manifested by joint deformity, substantial loss of range of motion, atrophy of surrounding muscles, and significant function impairment of ambulation and other activities of daily living, which has not improved after an appropriate, aggressive, and sustained course of outpatient therapy or in a therapy program in another less intensive rehabilitation setting immediately preceding the inpatient rehabilitation admission. The patient must also have the potential to improve his or her functioning with more intensive rehabilitation.

#### ***4.) Joint Replacements***

CMS added this condition to include patients who undergo knee and/or hip joint replacement during an acute hospitalization immediately preceding the IRF stay and who also meet at least one of the following specific criteria:

- patients who underwent bilateral knee or hip joint replacement surgery during the acute hospitalization, immediately preceding the IRF admission;
- patients who are extremely obese as measured by the patient's Body Mass Index (BMI) of at least 50 at the time of admission to the IRF; or
- patients considered to be "frail elderly," as determined by a patient's age of 85 or older at the time of admission to the IRF.

#### **Use of Comorbidities**

Beginning with cost reporting periods on or after July 1, 2004 and until July 1, 2007, CMS will calculate a providers' compliance threshold using comorbid conditions if all of the following criteria are met: (1) the principal diagnosis for which the patient is admitted to rehabilitation is not one of the conditions listed in 42 CFR §412.23(b)(2)(iii); (2) the patient also has a comorbidity that falls into one of the conditions listed in 42 CFR §412.23(b)(2)(iii); and (3) the comorbidity has caused the patient significant functional decline so that it alone would require intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities and which cannot be appropriately performed in another setting, such as inpatient hospital, skilled nursing facility, or home health or outpatient setting. The use of comorbidities to satisfy compliance with the rule will expire for cost reporting periods beginning on or after July 1, 2007.

#### **CMS Future Research and Considerations**

CMS has also written into the rule issues for future consideration and discussion. It has indicated it will use the three-year transition period to analyze claims and patient assessment data to evaluate if and how the lowering of the compliance threshold and other policies stipulated in this final rule, affect admission trends and overall IRF utilization.

CMS expects to convene a research panel early in the transition period to consider which are the most appropriate clinical conditions for care in IRFs and to formulate a research agenda to assist in developing scientific studies to examine this question.

CMS states in the final rule it is also open to considering additional or alternative methods to classify a hospital as an IRF and to incorporate additional conditions under this regulation (for example, cardiac rehabilitation and cancer).

In addition, CMS has indicated that it will consider policy changes that would allow an IRF to use idle bed capacity to provide lower levels of rehabilitation, perhaps through a distinct payment rate commensurate with this level of service.