Eli's Rehab Report

IRFs: Get on the Cutting Edge of CMS's IRF Plans

Keep business as usual, experts recommend.

Feel like your inpatient rehab facility is hanging by a string? The compliance threshold for Medicare reimbursement freezing at 60 percent has offered the industry some relief, but there may be some more hope on the horizon.

Thanks to a mandate in the Medicare, Medicaid, and SCHIP Extension Act of 2007, the Centers for Medicare & Medicaid Services must report to Congress in 2009 and 2010 on what is -- and isn't -- working with the 75 percent rule. CMS has contracted with RTI International to prepare a report that includes public input on:

• whether Medicare beneficiaries have access to medically necessary rehab services -- and how the 75 percent rule affects their access to appropriate care

• whether alternative IRF classification could work, including a patient's functional status, diagnosis, and comorbidities

• whether IRF care is appropriate for the conditions outside the 13 specified in the 75 percent rule, and whether patient outcomes and costs are different when these cases are treated in different settings.

Public Forums Tell All

IRFs and IRF advocates across the nation gathered in February for a CMS town hall meeting and a CMS open door forum to discuss their beef with the current IRF classification criteria and to offer alternative solutions. "This is the first time since2002 that people have been able to talk about this issue [directly and formally to CMS]," says **Fran Fowler, FAAHC,** Atlanta-based managing director of Health Dimensions Group.And talk they did.

Shocking: The list of qualifying conditions for IRF status turned out to be nothing more than products of an informal discussion, according to **Leon Reinstein, MD,** past president of the American Academy of Physical Medicine & Rehabilitation. "In 1983 I was asked to chair a committee where we [AAPMR] were charged by HCFA to identify criteria to distinguish rehabilitation facilities and patients. ...As an afterthought, we were asked for the 10 most common diagnoses we see in inpatient rehab. In a nonscientific way, I walked up to the chalkboard, and we went around the room."

Reinstein never expected this information would be used in a CMS regulation almost 20 years later. "This was certainly not evidence-based; it was just people sitting around a table in the Chicago O'Hare Airport," he said.

Brainstorm: Among a slew of other concerns expressed, novel solutions arose too. "We believe that an accreditation model would better serve as an effective alternative [to the 75 percent rule's classification criteria]," said **Brian Boone, PhD,** president and CEO of CARF (the Commission on Accreditation of Rehabilitation Facilities).

CMS should "... adopt a services-based definition for an inpatient rehab hospital and eliminate the conditions based criteria altogether," suggested **Bruce Gans, MD,** chief medical officer of the Kessler Institute and chair of the American Medical Rehabilitation Providers Association. He pointed out that psychiatric hospitals, cancer centers, and other specialty facilities are not defined on the basis of individual diagnosis categories.

If that's not feasible, CMS should at least try to broaden the scope of qualifying conditions, Gans said, naming cardiac, cancer, transplant, and pain patients as cases to consider adding.

Keep Business As Usual for Now

While there's a ray of hope for some positive changes after these CMS forums, don't get too excited just yet. For CMS to

stay budget neutral, there will have to be give and take, Fowler warns. "It's too early to tell what will come of this study; we may get a little break here and there, but not one that will necessarily bring a great deal of relief."

Or it could be even more dismal: "I really do believe that within three years CMS is going to try to bundle postacute care payment," Fowler predicts.

Best bet: Find new ways to survive the current situation. For instance, start digging deeper into your potential admits. "Our research shows that about 20 percent of all rehab cases don't make it into acute because no one picks up the secondary or tertiary diagnoses that could otherwise qualify these cases," Fowler says.

Example: There are many cardiac patients who have arthritis, but no one's ever evaluated that way in acute care, Fowler says. Just make sure your documentation backs everything up.

Another strategy: Get a sharp, clinically savvy person to do your preadmission evaluations and to look for these hidden opportunities. "People underestimate the role of a good evaluation person; three to five admissions more than pays for that person's salary; that's not very much if you look at what the right person in this position could bring you," Fowler says.