Document hosted at JDSUPRA
http://www.jdsupra.com/post/documentViewer.aspx?fid=fcde792c-1dfc-41c5-9ace-4180c1365075

OBER | KALER
Attorneys at Law

Payment Matters™

January 23, 2008

Victory for IRFs, Mixed Bag of Relief and Scrutiny for LTCHs

Carel T. Hedlund
410-347-7366
cthedlund@ober.com

The Medicare, Medicaid and SCHIP Extension Act of 2007 (Act), signed into law on December 29, 2007, contained a number of provisions targeted at specific sectors of the industry. This article summarizes the provisions affecting inpatient rehabilitation facilities and long-term care hospitals.

Inpatient Rehabilitation Facilities (IRFs)

IRFs have fought for years against CMS's increasingly strict interpretations of the "75% Rule" whereby, to qualify as an IRF, at least 75% of admissions must have one or more of 13 specific conditions. They finally have achieved legislative relief. The Act

- Permanently changes the 75% Rule to a 60% Rule (at least until Congress changes it again).
- Permits continued use of comorbidities to determine whether patients meet the specified conditions.
- Requires CMS to report to Congress within 18 months on analysis of effect of 75% Rule, including alternatives, refinements, and conditions not included within rule that are common reasons for admissions to IRFs.

Long-term care hospitals (LTCHs)

While some of the provisions aimed at LTCHs provide at least temporary relief from payment limitations as sought by the industry, other provisions require increased scrutiny of the entire LTCH payment system.

The Good

- Three year exemption for freestanding and grandfathered LTCHs from the "25% rule," which limits the number of patients LTCHs can admit from acute care hospitals to 25% of admissions without payment adjustments.

In this Issue

Victory for IRFs, Mixed Bag of Relief and Scrutiny for LTCHs

CMS' Reliance On Unpublished Payment Principles Rejected by Federal Court

Private Payers Refusing to Pay for "Never Events"

Payment Group

Principals

Thomas W. Coons

Leslie Demaree Goldsmith

Carel T. Hedlund

S. Craig Holden

Julie E. Kass

Document hosted at JDSUPRA™
http://www.jdsupra.com/post/documentViewer.aspx?fid=fcde792c-1dfc-41c5-9ace-4180c1365075

Paul W. Kim (Counsel)

John F. Lessner

Robert E. Mazer

Christine M. Morse

Laurence B. Russell

Ray M. Shepard

Susan A. Turner

Associates

Kristin C. Cilento

Joshua J. Freemire

Donna J. Senft

Emily H. Wein

- For three years, urban Hospitals-within-Hospital (HwH) LTCHs can admit up to 50% of their admissions from co-located hospitals without payment adjustment; and rural and MSA-dominant HwH LTCHs can admit up to 75% of their admissions from co-located hospitals without payment adjustment.
- Three year moratorium on payment reductions for very short-stay outlier payments.
- Three year moratorium on one-time budget neutrality adjustment to LTCH PPS rates.

The Bad

- Three year moratorium on establishment and enrollment of new LTCHs or satellite locations unless certain criteria are met.
- Elimination of 0.71% inflation adjustment for FY 2008.

In the Meantime (The Ugly?)

- New definition of LTCH that requires, among other things, patient review process for screening patients prior to admission, validation within 48 hours of admission that admission criteria are met, regular evaluations throughout stay, and assessment of discharge options when continued stay criteria not met.
- CMS to study establishment of national LTCH facility and patient criteria to determine medical necessity, appropriateness of admission and continued stay at, and discharge from, LTCHs, and report to Congress with recommendations within 18 months.
- For three years, fiscal intermediaries and Medicare administrative contactors will conduct annual medical necessity reviews of admissions to LTCHs on a sample basis; such reviews are to "guarantee" that at least 75 percent of overpayments received by LTCHs for unnecessary admissions and continued stays will be identified and recovered; such reviews are to be funded by aggregated overpayments recouped from LTCHs for medically unnecessary admissions and continued stays.

Ober|Kaler's Comments: While LTCH providers were successful in getting at least temporary relief from payment restrictions, it is evident that Congress and CMS are intent on taking a long, hard look at LTCHs to determine what role they can and should play in the spectrum of care. LTCHs should prepare for increased scrutiny of the medical necessity of their admissions by reviewing admissions criteria and ensuring that medical records contain complete documentation.

Copyright© 2008, Ober, Kaler, Grimes & Shriver