

pay \$2.87 million in restitution. He was caught misdiagnosing patients with a rare vascular

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Value ~ Added

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Rehabilitation Hospitals and Proposed Changes to the "75% Rule"

Current regulations require that all Inpatient Rehabilitation Facilities (IRFs) provide at least 75% of their services to patients that fall into the following ten categories of treatment:

- ❖ Stroke
- ❖ Fracture of Femur
- ❖ Spinal Cord Injury
- ❖ Brain Injury
- ❖ Congenital Deformity
- ❖ "Polyarthritis" (*see discussion below)
- ❖ Amputation
- ❖ Neurological Disorders
- ❖ Major Multiple Trauma
- ❖ Burns

However, in July 2002 - responding to a petition made by the American Academy of Physical Medicine & Rehabilitation - the Centers for Medicare and Medicaid Services announced that it would temporarily suspend any actions based on a review of a rehabilitation hospital's (or unit's) compliance with the so-called "75% Rule."

Rehab hospitals argued that these ten categories no longer reflected the wide range of services provided at today's rehabilitation facilities. As an alternative requirement, industry representatives had proposed changing the eligibility criteria from the current ten categories of treatment to a broader set of twenty-one rehabilitation impairment categories ("RICs"), which formed the underlying basis for payments under the new IRF PPS (i.e. the system's 100 "case mix groups" are organized into the twenty-one RICs).

During the temporary suspension period, CMS continued to require that rehab facilities file a yearly attestation to assess the industry's compliance with the regulations, but organizations that no longer meet

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Rehab. hospitals proposed changes continued...

the criteria of the "75% Rule" will not lose their status as a rehab hospital. In addition, Medicare fiscal intermediaries have been precluded from taking any action upon facilities that failed to meet the requirement (a failure that would otherwise result in the facility receiving payments under the standard acute hospital IPPS.)

In a May 16, 2003 proposed rule, CMS announced its intention to recommence enforcement of the "75% Rule" for cost reporting periods beginning October 1, 2003. However, in a new proposed rule issued on September 9, 2003, CMS has revisited the IRF classification criteria, and has made significant revisions regarding its enforcement. Please note, however, that the rule is still in the proposed stage. CMS has not yet issued a final version. The official comment period for the proposed rule closes on November 3, 2003. CMS intends to publish a final rule as soon thereafter as possible.

The most notable of the proposed changes is that the percentage of total IRF patient population used to distinguish an IRF from an acute care hospital would be decreased from 75% to 65%. CMS would continue to use the provider's total patient population to determine compliance with the proposed "65% Rule," but the agency would also establish an administrative presumption that if the facility's Medicare patient population complies with the rule, the facility's total population complies as well.

The proposed rule would also adjust the list of ten qualifying treatment categories by removing "polyarthritis" from the list, and by replacing that term with three more clearly stated arthritis conditions. The "polyarthritis" term had led to significant confusion in the past, as it did not represent any clearly defined medical condition. After gathering feedback from experts in rheumatology and rehabilitation, CMS is proposing to expand the term "polyarthritis" to the three following categories:

- ❖ Active polyarticular rheumatoid arthritis, psoriatic arthritis and seronegative arthropathies
- ❖ Systemic vasculidities with joint inflammation
- ❖ Severe or advanced osteoarthritis

Compliance with the original "75% Rule" was based on a patient's primary diagnosis. In contrast, the proposed rule would also allow IRF's to include patients with a secondary medical condition that meets one of the twelve new conditions toward the 65% threshold. A secondary medical condition refers to a condition that was not the primary reason for admittance, but would itself require rehabilitation treatment regardless of other conditions. Beginning October 1, 2003, patients with a secondary condition matching one of the twelve treatment categories would count toward compliance with the "65% Rule" only if all of the following criteria are met:

- ❖ The patient is admitted for rehabilitation for a condition that does not match one of the twelve treatment categories
- ❖ The patient also has a secondary condition that falls into one of the twelve treatment categories listed in the proposed rule
- ❖ The secondary condition has caused significant functional ability decline in the individual regardless of the admitting condition, rehabilitation treatment would be required that is unique to the IRF's and could not be performed at another facility

The proposed rule would change the period of time to review patient data to determine compliance with the proposed "65% Rule" from the most recent twelve-month cost reporting period to the most recent, appropriate and consecutive twelve-month time period. In the past, compliance with the "75% Rule" would have been determined by looking at a full year of cost report data (e.g. January 1 2004, to December 31, 2004). However, because the review process often takes up to three-to-four months, rehab providers not in compliance with the rule would not have been required to convert to the acute hospital IPPS until January 1, 2005, i.e. the beginning of the next cost reporting period. To address this time lag, CMS would begin using data from the last three-to-four months of the previous year (2003, in this example) and data from the first eight-to-nine months of the current year (2004) to assess compliance with the new "65% Rule." A determination of compliance could be reached by January 1, 2004, the beginning of the next cost reporting period.

The enforcement of this proposed rule would not recommence until January 1, 2004, and the new compliance threshold would remain at 65% until January 1, 2007. Over the intervening three-year period - January 1, 2004 to January 1, 2007 - CMS plans to closely review both claims and patient assessment data to evaluate trends in admission and overall IRF utilization. Through this analysis, CMS believes it will be able to evaluate the overall impact of the agency's new policies and assess the need for future policy development. At the end of this three-year period, the "65% Rule" would return to the "75% Rule," and secondary conditions would no longer be counted toward the percentage of total patient population.

The Massachusetts Hospital Association submitted official comments on the proposed rule to CMS, including a request to temporarily lower the patient ratio threshold to 50% during a period in which an expert panel could be convened to discuss the rule. MHA notes that recent advances in medical rehabilitation necessitate further discussion to determine clinical appropriateness of medical conditions used to determine IRF classification. The MHA suggests that the new proposed rule fails to provide needed clarity, potentially leading to increased confusion for providers and fiscal intermediaries as they attempt to define and sustain a course of therapy for rehab patients.



Summary of Health Care Fraud and Abuse Control Program Annual Report for Fiscal Year 2002

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a Health Care Fraud and Abuse Control Program (HCFAC). Acting under the direction of the Attorney General and the Secretary, this program endorses Federal, state, and local law enforcement activities in regards to health care fraud and abuse. All monetary settlements are deposited into the Medicare Trust Fund. Under HIPAA, the Department of Health and Human Services (HHS) and the Office of Inspector General (OIG) are required to report the amounts deposited and appropriated to the Fund on an annual basis.

On October 8, 2003, the HCFAC FY 2002 Annual Report was published, stating that \$1.8 billion was won or negotiated by the Federal government in judgments, settlements, and administrative impositions in health care fraud and abuse cases. The government has collected over \$1.6 billion, of which \$1.4 billion was returned to the Medicare Trust Fund. This is reportedly the largest amount returned to the fund since the inception of the program.

In FY 2002, Federal prosecutors filed 361 criminal indictments. This number is down 23% from FY 2001 where 445 criminal indictments were filed. 480 defendants were convicted for health care fraud related crimes during 2002, and HHS excluded 3,448 individuals and entities from the Medicare and Medicaid programs. We also see a decline in excluded individuals from FY 2001 to 2002 by 9%.

Some examples of areas included in the HHS and the Department of Justice (DOJ) prosecutions attributable to the \$1.8 billion in settlements are discussed below.

Quality of Care

The area concerning quality of care has proved to be the most effective for collaboration on enforcement and oversight of issues. There has been an increase of attention by the OIG on quality of care issues. In the past few years we have seen a rise of topics relating to quality of care targeted in the OIG Work Plan initiatives – perhaps a direct result of the findings / settlements reported in the HCFAC report.

For example, a California physician was recently convicted of multiple felony counts and ordered to pay \$2.87 million in restitution. He was caught misdiagnosing patients with a rare vascular disease that required patient to obtain expensive medical devices.

Attention to the quality of care in nursing homes is also on the rise. The OIG recently hosted a symposium focused on improving the quality of care in nursing home settings. Several areas have already been introduced as focus points, including: psychotropic drug use and the physician's role in home health.

Pharmaceuticals

An area that remains of high importance is drug pricing. A number of investigations, audits, and evaluations are focused on whether the government is paying reasonable amounts for covered prescription drugs.

During FY 2002, the twenty-first person in Maine was sentenced for leading a large-scale distribution ring of the drug OxyContin. The man is sentenced to twenty-one years in prison and ordered to pay \$6,000 in restitution.

Hospitals

The HCFAC program is paying attention to improperly reported and paid discharges for hospitals that have been consolidated – which is considered a change of ownership and therefore the surviving hospital would be entitled to the Medicare payments.

During a preliminary review, the OIG discovered fifteen hospitals that were improperly paid a total of \$8 million for 1,118 prospective payment system discharges. Each of the offending hospitals did not have an understanding of the rules on hospital consolidations.

The OIG has played its part in bringing about judgments and settlements touched on above. HHS acted on recommendations from the OIG that resulted in \$150.2 million in disallowances and improperly paid health care funds in 2002. The HHS / OIG continue to work with CMS to identify vulnerabilities and develop recommendations to combat such vulnerabilities found during audits and evaluations.



Compliance Corner

An update on recent activity by the Department of Health and Human Services Office of Inspector General (HHS-OIG)

The Office of Inspector General (OIG) has released their 2004 Work Plan. The Work Plan is a list of projects the OIG finds to be the leading potential causes of fraud, waste, and abuse. The Office of Inspector General Work Plan sets forth various projects to be addressed during the fiscal year by the Office of Audit Services, Office of Evaluation and Inspections, Office of Investigations, and Office of Counsel to the Inspector General. The Work Plan includes projects planned in each of the Department of Health and Human Services' major entities: the Centers for Medicare and Medicaid Services (CMS), public health agencies, and the Administration for Children and Families. Information is also provided on projects related to issues that cut across departmental programs, including state and local government use of federal funds, as well as the functional areas of the Office of the Secretary. Some of the projects described in the Work Plan are statutorily required, such as the audit of the department's financial statements, which is mandated by the Government Management Reform Act.

The Work Plan can act as a "blue print" in designing compliance initiatives. The OIG outline specific topics they will be focusing their audits on and the regulations involved in the decision-making process. Providers can use this information to evaluate their own policies and procedures to determine if they are in check with the OIG's interpretations.

It should be noted that some prior Work Plan topics have taken a back seat to more recent focus areas. However, the OIG can renew any topic without notice, so past topics should not be neglected.

Here is a quick run-down of OIG focuses included in the Work Plan for 2004.

- **Diagnosis-Related Group Payment Limits** – The OIG will assess the ability of Medicare contractors to limit payments to hospitals for patients who are discharged from a prospective payment system inpatient hospital and admitted to one of several post-acute-care settings. This limitation applies to certain DRGs. Prior OIG reviews indicated a lack of controls resulting in significant overpayments.
- **Outpatient Cardiac Rehabilitation Services** – At the request of CMS, the OIG will determine whether cardiac rehabilitation services provided by hospital outpatient departments met Medicare coverage requirements. Medicare covers such rehabilitation under the "incident-to" a physician's professional services benefit, which requires that the services of non-physician personnel be furnished under the physician's direct supervision. Direct supervision means that a physician must be in the exercise program area and immediately available and accessible for a medical emergency at all times during the exercise program. At one hospital, the OIG identified approximately \$10,000 in overpayments that resulted from noncompliance with the supervision requirements.
- **Home Health Payment System Controls** – The OIG will review the appropriateness of prospective payments to home health agencies and the adequacy of controls intended to ensure that services are needed and properly paid. They will also determine whether services were properly coded and whether any services were inappropriately unbundled and paid separately by Medicare. In addition, the OIG will determine whether payments were inappropriately made for overlapping home health episodes and whether payments for dually eligible beneficiaries were appropriate.
- **Physicians / Use of Modifiers with National Correct Coding Initiative Edits** – The OIG is placing a lot of emphasis on the use of modifiers for physician services. They will determine whether claims were paid appropriately when modifiers were used to bypass National Correct Coding Initiative edits. The initiative, one of CMS's tools for detecting and correcting improper billing, is designed to provide Medicare Part B carriers with code pair edits for use in reviewing claims. A provider may include a modifier to allow payment for both services within the code pair under certain circumstances. In 2001, Medicare overpaid \$565 million to providers who included a modifier in these circumstances.

CMS Program Memorandums

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Notice of Interest Rate for Medicare Overpayments and Underpayments

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

Action: 8-11-03, Transmittal No. AB-03-122, Change Request 2432.

The Supplemental Security Income (SSI)/Medicare Beneficiary Data for Fiscal Year 2002 for Inpatient Prospective Payment System (IPPS) Hospitals

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

Action: 8-8-03, Transmittal No. A-03-067, Change Request 2868.

Consolidation of Claims Cross-over Process

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

Action: 8-15-03, Transmittal No. AB-03-125, Change Request 2836.

Update to Health Care Claims Status Category Codes and Health Care Claim Status Codes for Use with the Health Care Claim Status Request and Response ASC X12N 276/277

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

Action: 8-22-03, Transmittal No. AB-03-131, Change Request 2786.

Fiscal Year (FY) 2004 Inpatient Prospective Payment System (IPPS), Long Term Care Hospital (LTCH), and Other Bill Processing Changes

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

Action: 8-22-03, Transmittal No. A-03-073, Change Request 2891.

Clarification – ICD-9 Coding

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

Action: 8-22-03, Transmittal No. B-03-064, Change Request 2857.

Inpatient Rehabilitation Facility (IRF) Annual Update: Prospective Payment System (PPS) Pricer Changes for FY 2004

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

Action: 8-29-03, Transmittal No. A-03-074, Change Request 2894.

Correction to Quarterly Update of HCPCS Codes Used for Home Health Consolidated Billing Enforcement

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

Action: 8-29-03, Transmittal No. AB-03-136, Change Request 2892.

October Medicare Outpatient Code Editor (OCE) Specifications Version 19.0 For Bills From Hospitals That Are Not Paid Under the Outpatient Prospective Payment System (OPPS)

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

Action: 9-5-03, Transmittal No. A-03-077, Change Request 2897.

2004 Healthcare Common Procedure Coding System (HCPCS) Annual Update Reminder

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

Action: 9-12-03, Transmittal No. AB-03-140, Change Request 2896.

Implementation of Certain Initial Determination and Appeal Provisions Within §521 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

Action: 9-26-03, Transmittal No. AB-03-143, Change Request 2251.

Conflicting Policies with Provider Reimbursement Manual 15-1, Section 2771

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

Action: 9-26-03, Transmittal No. A-03-081, Change Request 2847.



Update on the New Prospective Payment System for Psychiatric Hospitals (and Units)

The Balanced Budget Refinement Act of 1999 mandated the development of a new, per-diem prospective payment system (“PPS”) for payment for the inpatient hospital services of psychiatric hospitals (and units). This new system was supposed to become effective for cost reporting periods beginning on or after October 1, 2002.

CMS continues the process of developing a proposed rule. The CMS Quarterly Provider Update released October 2003 did list a “Prospective Payment System for Psychiatric Hospitals for FY 2004” as a proposed regulation under development for the upcoming quarter. However, the January, April, and July 2003 Quarterly Updates also listed the regulation as “under development” for those quarters as well.

The PPS ultimately will be published as a proposed rule (allowing time for public comment), and then released as a final rule, so implementation does not appear to be imminent.

In the meantime, the August 1, 2003 Final Rule updating Medicare hospital rates for Fiscal Year 2004 states that psychiatric hospitals and units will continue to be paid on a retrospective, reasonable cost basis – i.e. in accordance with the existing regulations. Until the implementation of the new PPS, payments will continue to be based on the hospital’s (or unit’s) Medicare inpatient operating costs, not to exceed the applicable “ceiling.” (This ceiling is computed using the provider’s target amount from the previous cost reporting period, which is updated by the hospital market bucket rate-of-increase, and then multiplied by the number of Medicare discharges.)

For cost reporting periods beginning on or after October 1, 1997 through September 30, 2002, the target amounts for three classes of exempt providers – psychiatric hospitals (and units), rehabilitation hospitals (and units), and long-term care hospitals – were subject to caps calculated based on the national seventy-fifth percentile of the target amounts for each class for cost reporting periods that ended during FY 1996. The resulting amounts were updated on an annual basis by the applicable market basket index.

As of last year, however, existing psychiatric hospitals (and units) whose initial cost reporting period began before October 1, 1997 are no longer subject to caps on the target amounts for cost reporting periods beginning on or after October 1, 2002.

Pending the implementation of the awaited PPS, the status of bonus payments and continuous improvement bonus payments also remain unchanged for psychiatric hospitals (and units).

Under 42 CFR 413.40(d)(2), if a psychiatric hospital’s (or unit’s) allowable net inpatient operating costs for a cost reporting period are less than, or equal to, the hospital’s ceiling, the hospital is paid a bonus in the amount of either the lower of (a) 15.0% of the difference between costs and the ceiling; or (b) 2.0% of the ceiling. For Fiscal Year 2001, the latter percentage was increased to 3.0% for psychiatric providers, but then reverted back to 2.0% beginning October 1, 2001. The bonus payment structure continues to remain in effect until the new prospective payment system comes on-line. (Under 413.40(3), psychiatric hospitals (and units) are also eligible to receive supplemental payments if net inpatient operating costs are greater than 110% of the ceiling. This structure also remains in effect.)

Under 42 CFR 413.40(d)(4), for cost reporting periods beginning on or after October 1, 1997 through September 30, 2002, eligible hospitals (and units) also received continuous improvement bonus payments equal to the lesser of (a) 50.0% of the amount by which the hospital’s operating costs were less than expected costs for the period or (b) a certain percentage of the ceiling (ranging from 1.0%-2.0%, depending on the year). To qualify, operating costs per discharge for the period had to be less than the least of the following: the target amount, trended costs, and expected costs. The continuous improvement bonus structure expired at the end of Fiscal Year 2002, and has not been renewed.

In addition to the existing reimbursement methodology for inpatient operating costs described above, psychiatric hospitals (and units) also receive Medicare reimbursement for capital-related costs. Under 42 CFR 413.40(3), the definition of net inpatient operating costs excludes capital-related costs. Psych providers are reimbursed for capital-related costs through a separate cost pass-through based on Medicare-allowed incurred expenses.

Section 4412 of the Balanced Budget Act implemented a mandatory 15% reduction to capital-related costs for psychiatric hospitals (and units). This reduction was in effect for portions of cost reporting periods occurring on or after October 1, 1997 through September 30, 2002. The reduction expired at the beginning of Fiscal Year 2003, however, and is no longer in effect.

Federal Register Summary

Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities Update

8-4-03 (Vol. 68, No. 149, pages 46035-46072)

Agencies: Centers for Medicare & Medicaid, HHS

Action: Final rule.

Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates

8-1-03 (Vol. 68, No. 148, pages 45345-45672)

Agencies: Centers for Medicare & Medicaid, HHS

Action: Final rule.

Changes to the Inpatient Rehabilitation Facility Prospective Payment System and Fiscal Year 2004 Rates

8-1-03 (Vol. 68, No. 148, pages 45673-45728)

Agencies: Centers for Medicare & Medicaid, HHS

Action: Final rule.

Electronic Submission of Medicare Claims

8-15-03 (Vol. 68, No. 158, pages 48805-48813)

Agencies: Centers for Medicare & Medicaid, HHS

Action: Interim final rule with comment period.

This interim final rule with comment period implements the statutory requirement that claims for reimbursement under the Medicare Program be submitted electronically as of October 16, 2003, except where waived. This rule identifies those circumstances for which mandatory submission of electronic claims to the Medicare Program is waived.

Electronic Submission of Cost Reports

8-22-03 (Vol. 68, No. 163, pages 50717-50722)

Agencies: Centers for Medicare & Medicaid, HHS

Action: Final rule.

Modifications to Managed Care Rules

8-22-03 (Vol. 68, No. 163, pages 50839-50859)

Agencies: Centers for Medicare & Medicaid, HHS

Action: Final rule.

State Allotments for Payment of Medicare Part B Premiums for Qualifying Individuals

8-22-03 (Vol. 68, No. 163, pages 50790-50793)

Agencies: Centers for Medicare & Medicaid, HHS

Action: Final rule.

Time Limitation on Price Recalculations and Recordkeeping Requirements Under the Drug Rebate Program

8-29-03 (Vol. 68, No. 168, pages 51912-51917)

Agencies: Centers for Medicare & Medicaid, HHS

Action: Final rule with comment period.

Changes to the Criteria for Being Classified as an Inpatient Rehabilitation Facility

9-9-03 (Vol. 68, No. 174 Pages 53265-53280)

Agencies: Centers for Medicare & Medicaid, HHS

Action: Proposed Rule.

This proposed rule would revise the classification criterion, commonly known as the "75 percent rule," used to classify a hospital as an inpatient rehabilitation facility (IRF). This proposed rule would also modify and expand the medical conditions listed in the 75 percent rule regulatory requirements as well as lower the percentage of patients required to fall within one of the specified list of medical criteria.

Time Limitation on Price Recalculations and Recordkeeping Requirements Under the Drug Rebate Program; Correction

9-26-03 (Vol. 68, No. 187, pages (55527-55528))

Agencies: Centers for Medicare & Medicaid, DHHS

Action: Final Rule; correction.

Requirements for Paid Feeding Assistants in Long Term Care Facilities

9-26-03 (Vol. 68, No. 187, pages (55528-55539))

Agencies: Centers for Medicare & Medicaid, DHHS

Action: Final Rule.

Contact Feeley & Driscoll

Please visit www.fdcpa.com/healthcare.htm to receive the latest health care news and the dates and agendas of our upcoming Reimbursement Roundtables for Hospitals and Long Term Care Providers

If you have any questions or would like to discuss further any of the issues discussed in Value Added with one of our health care specialists, please contact us at (617) 742-7788 or

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CMS Program Memorandums

Update of Rates and Wage Index for Ambulatory Surgical Center (ASC) Payments Effective October 1, 2003

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

Action: 8-8-03, Transmittal No. AB-03-116, Change Request 2871.

Informing Beneficiaries About Which Local Medical Review Policy (LMRP) and/or National Coverage Determination (NCD) is Associated with Their Claim Denial

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

Action: 8-1-03, Transmittal No. AB-03-112, Change Request 2342.

Durable Medical Equipment Regional Carriers (DMERCs – Additional Instructions for Health Insurance Portability and Accountability Act (HIPAA) Implementation of National Drug Codes (NDCs) and the NCPDP Format

Agencies: Department of Health & Human Services (DHHS) and Centers for Medicare & Medicaid Services (CMS)

Action: 8-1-03, Transmittal No. B-03-056, Change Request 2760.

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Feeley & Driscoll, P.C.

Health Care Roundtable Seminars

As you know, Feeley & Driscoll, P.C. is hosting a series of complimentary roundtables designed to help you and your staff stay abreast of breaking issues impacting your institution's financial position.

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