So Your Doctor Said You Need Some Rehabilitation?

Post-Acute Eligibility Determination For Rehabilitation Services

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January 12, 2017

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Conflicts of Interest

Disclosures:

- I have no conflicts of interests to disclose for this presentation; I have no financial relationship with a *commercial interest*[1] in the products and services which are pertinent to the content of this educational presentation.

- I work for Mary Free Bed Rehabilitation Hospital, a non-profit 503(c) organization that is a provider of clinical services directly to patients, including but not limited to hospitals, health care agencies and independent health practitioners. This organization's purpose is to improve and support the delivery of health care to patients.

[1]*Commerical interest means an entity producing, marketing, reselling, or distributing healthcare goods or services consumed by or used on patients, or an entity that is owned or controlled by an entity that produces, markets resells, or distributes healthcare goods or services consumed by or used on patients.*

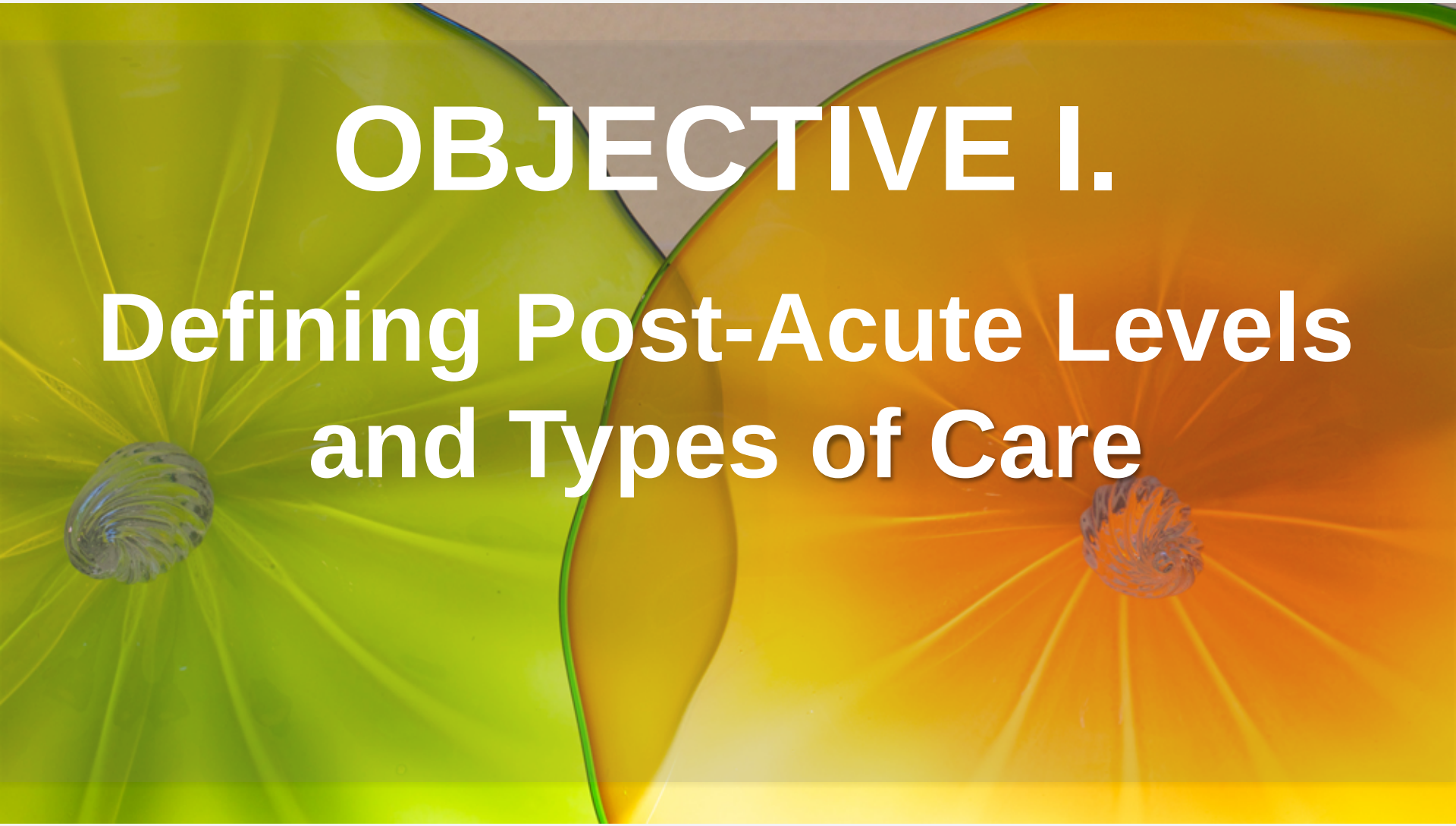
Learning Objectives

WE WILL LEARN:

I. The defined post-acute levels and types of care in the community.

II. Which criteria are used to determine patient eligibility for each level of care in the continuum.

III. The importance of care coordination within the care/case manager role during this process.


OBJECTIVE I.
Defining Post-Acute Levels and Types of Care

Post-Acute Levels of Care

Levels and Types:

I. **Continued Acute Care**
   A. LTACH – (Long-term Acute Care Hospital)

II. **Post-Acute Care**
   A. Acute Rehabilitation (IRF = Inpatient Rehab Facility)
   B. Sub-Acute Rehabilitation (SNF = Skilled Nursing Facility)
   C. Home or Community Placement with:
      1. Home Health Care (Certified by Medicare)
      2. Private Duty
      3. Outpatient
   D. Long-Term Care Facility

OBJECTIVE II.

Criteria Used to Determine Eligibility for Levels of Care

LTACH

Long-Term
Acute Care Hospitals

Long-Term Acute Care Hospital

LTACHs specialize in treating patients who have more than one serious condition, but who may improve with time and care, and return home. No longer appropriate for care in acute care hospital

Medical Necessity Criteria:

- Stable to transfer LTACH
- Patient needs cannot be safely met in a less restrictive setting (i.e. IRF or SNF)
- Expected length of stay is generally greater than 25 days
- Intensive management of complex medical needs, such as:
  - o multiple / prolonged IV therapies
  - o frequent intervention (≥ 6 times/day) for complex conditions such as:
    - ✓ ventilator management
    - ✓ cardiac monitoring
    - ✓ complex wound care
  - o Need specialized equipment like cardiac monitors, on-site dialysis, or surgical suites
  - o Rehabilitation (PT, OT and/or Speech)

Acute Rehabilitation IRF

Criteria for Acute Rehab / IRF

Standards and Regulations set by CMS (Centers for Medicare & Medicaid Services)

1. **Appropriate IRF diagnosis** (≥ 60% patients must have a CMS 13 Rehab diagnosis / 40% must have an approved dx)
2. **Medical Necessity** - Rehabilitation physician providing close medical supervision and 24 hour rehabilitation nursing
3. **Relatively intense therapy** (OT, PT, Speech, Orthotics/Prosthetics) 3 hours/day at least 5 days/week
4. **Interdisciplinary team approach** to program delivery and coordinated program of care
5. **Significant practical improvement** for realistic goals (we use the FIM™) within an appropriate length of time
6. **Discharge plan** – must have safe / reasonable d/c plan

Criteria for Acute Rehab / IRF

1. **Appropriate IRF diagnosis**
2. Medical necessity
3. Relatively intense therapy
4. Interdisciplinary team approach
5. Significant practical improvement
6. Discharge plan

1. Appropriate IRF Diagnosis

CMS 13 IRF Diagnoses

1. Stroke
2. Spinal cord injury
3. Congenital deformity
4. Amputation
5. Major multiple trauma
6. Hip fracture
7. Brain injury

1. Appropriate IRF Diagnosis

(CMS 13 IRF Diagnoses)

8. Neuro disorders
9. Burns
10. Active, polyarticular arthritis, psoriatic arthritis, seronegative arthropathies
11. Systematic vasculidities with joint inflammation
12. Severe or advanced osteoarthritis (involving two or more major weight bearing joints)
13. Knee/Hip replacement (*If traditional Medicare ->immediately preceding IRF stay if bilateral, BMI = 50+, or if 85+ years old)*

1. Appropriate IRF Diagnosis

CMS 60% Rule (for IRF's)

At least 60% of all IRF patients must fall within the CMS 13 diagnoses

The other 40% of patients can be from other diagnoses such as Deconditioned or Debility as long as they meet all other IRF criteria.

Criteria for Acute Rehab / IRF

1. Appropriate IRF diagnosis
2. **Medical necessity**
3. Relatively intense therapy
4. Interdisciplinary team approach
5. Significant practical improvement
6. Discharge plan

2. Medical Necessity

According to CMS:

"*Services must be reasonable and necessary (in terms of efficacy, duration, frequency, and amount) for the treatment of the patient's condition*."

2. Medical Necessity

- The presence of certain **comorbid conditions** (*in addition to the rehabilitation diagnosis and functional level*) support medical necessity in an IRF setting.
- Some of those conditions include:
  - ✓ Diabetes
  - ✓ Hypertension
  - ✓ Morbid Obesity
  - ✓ Dysphagia

Criteria for Acute Rehab / IRF

1. Appropriate IRF diagnosis
2. Medical necessity
3. **Relatively intense therapy**
4. Interdisciplinary team approach
5. Significant practical improvement
6. Discharge plan

3. Relatively Intense Therapy

According to CMS:

- "If a patient needs a relatively intense rehab program requiring an interdisciplinary coordinated team approach to upgrade ability to function."
- 3 hours/day at least 5 days/week *(not all at one time & includes all functional goal areas)*
- Only PT, OT, SLP (SLP if indicated), and Orthotics/ Prosthetics (if indicated) count toward the 3 hours/day.

3. Relatively Intense Therapy

Patients served at IRF's require more intensive rehab (at least *3 hrs/day 5 days out of 7 beginning with the day of admission*)

Traditional Medicare does not require pre-certification. *They only require that we follow the IRF rules as outlined in the Federal Register.*

3. Relatively Intense Therapy

CMS Exception

•15 Hours Per 7 days of Therapy Based on Medical Need (900 minutes/7 days) – *in certain well-documented cases for patients with other medical issues (i.e. dialysis, MS) and rehab potential.*

- If they meet all other CMS medical necessity guidelines
- Rehab physician must document the need medical need
- Smaller therapy increments
- Very specific plan with incremental goals to be documented by the rehab team (*in weekly team conf*)

Criteria for Acute Rehab / IRF

1. Appropriate IRF diagnosis
2. Medical necessity
3. Relatively intense therapy
4. **Interdisciplinary team approach**
5. Significant practical improvement
6. Discharge plan

4. Interdisciplinary Team Approach

There is a distinction between medical necessity for *individual* therapy services (**multi-disciplinary** approach) as common in a SNF

and

the medical necessity of providing *coordinated*, *comprehensive* and **inter-disciplinary** services in an IRF setting.

4. Interdisciplinary Team Approach

This includes a weekly formal team conference for each patient that:

1. Is directed by the rehabilitation physician and include a representatives from nursing and each therapy discipline
2. Demonstrates collaboration in the rehabilitation process between all therapies and nursing.

Criteria for Acute Rehab / IRF

1. Appropriate IRF diagnosis
2. Medical necessity
3. Relatively intense therapy
4. Interdisciplinary team approach
5. **Significant practical improvement**
6. Discharge plan

5. Significant Practical Improvement

How can we identify “practical improvement”?

- Identify the patient / family overall functional goals.
- Measurable improvement in medical and functional areas (FIM).
- Clarify remaining barriers to community discharge and need for continued professional nursing and therapy services in an inpatient setting.
- Case Mix Group (CMG) - Estimate of length of stay.

Criteria for Acute Rehab / IRF

1. Appropriate IRF diagnosis
2. Medical necessity
3. Relatively intense therapy
4. Interdisciplinary team approach
5. Significant practical improvement
6. **Discharge plan**

6. Discharge Plan

Prior to admission, potential IRF patients must have a plan to return to live in a community setting, such as:

- ✓ Home
- ✓ Home of friend/family
- ✓ Assisted Living
- ✓ Transitional Living

- The plan must include reasonable supports that may be needed at the time of discharge for safety. These may include 24 hour supervision or access to other types of care / services.

6. Discharge Plan

- In some cases, patients do not achieve a level of functional or medical independence for a community discharge or the amount support required exceeds the family/support system's resources.
- In these cases, a discharge to a skilled nursing facility or long-term care setting may be appropriate.

Sub-Acute Rehab / SNF

Sub-Acute Rehab / SNF

- **Some excellent rehabilitation candidates do not fit into the Acute Rehab / IRF "Window of Eligibility"**

- **Sub-Acute / SNF based rehabilitation meets the need for rehabilitation to serve people who do not qualify for the Acute Rehab / IRF level of care due to:**
  - Unable to tolerate a minimum of 3 hours therapy / 5 our of 7 days
  - Unable to tolerate a minimum of 15 hours of therapy over a 7 day period
  - Too high functioning (i.e. can already walk distances for a home-like setting) but unable to live alone or lack the supports to be safe in the home setting
  - Too low functioning and would benefit from a slower paced rehabilitation program

- **Criteria for skilled nursing facility admissions is not as tightly defined as in the Acute Rehab / IRF level of care.**

Criteria for Sub-Acute Rehab / SNF

CMS Standard: Section 1819

- Medicare Part A benefit covers **UP TO** 100 days of skilled care:
  - Daily skilled nursing, skilled PT/OT and/or Speech, or a combination of both
  - Medical social work services
  - Drugs, biologicals, appliances, orthotics
  - 3-day hospital stay required prior to admission for Medicare
  - Medicare A does not cover custodial or long-term care

Criteria for Sub-Acute Rehab / SNF

“Skilled Care” defined by CMS:

- *Requiring the skills of qualified technical or professional health level personal, such as RN, LPN, PT, OT, SLP, provided directly or under supervision of these personnel*

- *Inherent complexity of service such that it can only be performed by skilled rehabilitation personnel*

Home Health Services

Home Health Services
(Medicare Certified)

Eligibility Criteria:

- Referral by a physician who has conducted a face to face encounter to determine the need for healthcare services based on clinical findings
- The patient is:
  - Unable to safely leave home independently because of a medical condition
  - Had been able to leave home with minimal effort but there has been a change
- The patient is now confined to home due to a medical condition, such as:
  - Arthritis and weakness limiting endurance and increased risk for falls outside of the home environment
  - Unstable gait and muscle weakness *(list reason)*
  - Pain with activity *(i.e. that limits functional mobility)*
  - Shortness of breath after walking short distances requiring frequent rest breaks
  - Cognitive deficits that impair orientation, judgment, or decision making
  - Chest pain with exertion *(list reason)*
  - Medical contraindication for the patient to leave the home *(list reason)*
  - Bed bound *(list reason)*
- Patient requires skilled nursing (and possibly other) services

Outpatient Rehabilitation

Private Duty Services

OBJECTIVE III.

Care Coordination Within the Care Manager Role During this Process

Care/Case Manager Role

Care Managers are SO important because:

- They can guide and educate patients, families, carriers, and allied healthcare professionals regarding available options for post-acute rehabilitation. This important function may occur:
  - During acute care
  - Prior to a planned surgery
  - After discharge home from acute care
  - Prior to or during planned transitions in levels of care
- They are able to see the big picture during the process of recovery to plan for the next level of care
- They are aware of quality standards and indicators that should be maintained by excellent service providers

Care/Case Manager Role

For example, “What to look for in a Sub-Acute / SNF”

- How frequently are Medical staff in building (i.e. 5 or 7 days/week, once per month?)
- Are there dedicated rehab units, gyms and treatment spaces?
- CARF accreditation
- What is the average length of stay ?
- Is there a comprehensive team approach
- Number Days/week of therapy
- Use of functional measures to monitor progress/outcomes
- Able to accept, admit and care for people with more complex medical issues than typical SNF?

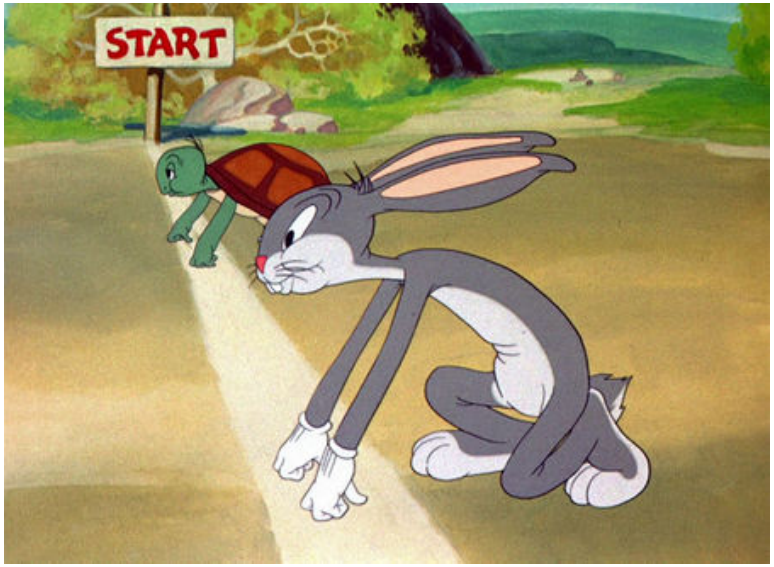
Would the Patient Benefit From a **Sprint** or a **Marathon**

Variable intensity of therapy:

- **SPRINT** **Acute Rehab / IRF** = Intensive rehab; shorter LOS

  or

- **MARATHON** **Sub-Acute Rehab / SNF** = Less intensive slower rate of recovery



Care/Case Manager

Eligibility Determination Tips

Acute Rehab / IRF:

- Medical necessity for inpatient level of care
- Ability to tolerate intense rehab (at least 3 hour / 5 out of 7 days)
- Steady rate of progress
- Clear plan to discharge to community (home or community setting)

Sub-Acute Rehab / SNF:

- Need “Skilled Care” at the SNF level of care
- Therapy can be lower intensity
- Can have variable rate of progress
- Discharge goal based on program and patient
  - sometimes community re-entry
  - sometimes rehab with plan to stay in long-term care setting
  - sometimes ‘see how rehab goes”

Care/Case Manager

Patient Example #1

- An 81-year-old woman who underwent a hip replacement. She is easily fatigued and her tolerance for therapy is variable. Her husband is at home but unable to assist her physically.

- Which level of care would this patient benefit from?
  - an Acute Rehab / IRF
  - a Sub-Acute Rehab / SNF

Care/Case Manager

Patient Example #2

- An 85-year-old man who is hospitalized for a (L) femur fracture. He has mild left hemiplegia from a CVA two years ago, is aphasic, has uncontrolled HTN, and is diabetic. He lives alone in a senior apartment complex. The patient tolerates intensive therapy and is motivated to go home.

- Which level of care would this patient benefit from?
  - an Acute Rehab / IRF
  - a Sub-Acute Rehab / SNF

QUESTIONS?

Thank you!

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