OIG AUDIT FINDINGS: MANY INPATIENT REHABILITATION FACILITY STAYS DID NOT MEET MEDICARE REQUIREMENTS (OCTOBER 10, 2018)

In September 2018, HHS Office of Inspector General ("OIG") issued audit Report No. A-01-15-00500 (the "Report") finding that out of 220 randomly sampled inpatient rehabilitation facility ("IRF") stays from 2013, *nearly 80 percent* did not meet Medicare coverage and documentation requirements. Specifically, for 175 of the 220 sampled stays at 135 IRFs, the medical record documentation did not support that IRF care was reasonable and necessary. Of the 175 stays that did not meet Medicare requirements, 146 stays did not meet both coverage and documentation requirements, and 29 stays met coverage requirements but did not meet documentation requirements.

According to the Report, a number of factors contributed to the high payment error rate:

1. Many IRFs did not have adequate internal controls to prevent inappropriate admissions;
2. Medicare Part A Fee-for-Service payment system ("FFS") lacked a prior authorization review process for IRF admissions;
3. CMS's educational efforts and post-payment reviews were unable to control an increasing improper payment rate reported by the Comprehensive Error Rate Testing ("CERT") program since OIG's 2013 audit period;
4. Administrative Law Judge hearings for IRF appeals did not always involve CMS participation to ensure that Medicare coverage and documentation requirements were accurately interpreted; and
5. The IRF payment system did not align cost with payments, which may have provided IRFs with a financial incentive to admit patients inappropriately.

Section 1862(a)(1)(A) of the Social Security Act states, "*no payment may be made under part A or part B for any expenses incurred for items or services, which ... are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.*" And yet, according to OIG, CMS did just that: on the basis of the audit's sample results, OIG estimated that Medicare paid IRFs nationwide $5.7 billion in 2013 for care to beneficiaries that was not reasonable and necessary.

Such a high IRF payment error rate strongly suggests that OIG, CMS or both will continue to monitor IRF admissions for medical necessity and take proactive steps to ensure IRF admissions are appropriate and payable under the Medicare coverage and documentation rules in order to safeguard the program. Indeed, IRF review currently is being conducted by CMS supplemental medical review contractors, and CMS already has recouped IRF payments made under traditional FFS Medicare. The Report can be found here.

BACKGROUND

IRFs consisting of both inpatient rehabilitation hospitals and rehabilitation units in acute-care hospitals provide intensive rehabilitation therapy for patients who, because of the complexity of their nursing, medical management and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care. Under the IRF Medicare prospective payment system ("PPS"), IRFs are reimbursed at a rate generally 2.5 times greater than the acute IPPS rate. The IRF reimbursement rates reflect the high level of resources required to effectively treat patients in need of aggressive rehabilitation.

The Report follows up on prior reviews that found some hospitals did not comply with the Medicare coverage and documentation requirements for IRFs.

MEDICARE COVERAGE AND DOCUMENTATION REQUIREMENTS

Medicare Coverage Requirements

The coverage requirements (42 CFR § 412.622(a)(3)) specify that, at the time of admission, the IRF must have a reasonable expectation that the patient meets all of the following requirements:

- Needs the multiple active and ongoing therapies of an acute inpatient rehabilitation interdisciplinary program, one of which must be

physical or occupational therapy;

- Requires supervision by a rehabilitation physician to assess the patient, both medically and functionally, and modify the course of treatment as needed to maximize the benefit from the rehabilitation process; and
- Is sufficiently stable to be able to actively participate and benefit from an intensive rehabilitation therapy program and demonstrate measurable improvement that is of practical value to the patient in improving functional capacity or adaptation to impairments.

Medicare Documentation Requirements

The Medicare IRF requirements (42 CFR §§ 412.622(a)(4) and (5)) specify that the patient's medical record at the IRF must include the following types of documentation with all required elements:

- Comprehensive pre-admission screening;
- Post-admission rehabilitation physician evaluation;
- Individualized overall plan of care developed and documented by a rehabilitation physician; and
- A demonstration that the patient requires an interdisciplinary approach to care with weekly interdisciplinary team meetings led by a rehabilitation physician.

OIG'S RECOMMENDATIONS TO CMS IN LIGHT OF HIGH PAYMENT ERROR RATE

OIG made the following recommendations to CMS with which CMS concurred:

- Educate IRF clinical and billing personnel on Medicare coverage and documentation requirements and work with providers to identify, develop and share compliance best practices that may lead to improved internal controls;
- Increase oversight activities for IRFs, such as post-payment medical review;
- Work with the Office of Medicare Hearings and Appeals to further evaluate the ALJ hearing process and make any necessary improvements to ensure that Medicare coverage and documentation requirements for IRF care are fairly represented; and
- Reevaluate the IRF payment system, which could include:
  - Conducting a demonstration project requiring prior authorization for Part A IRF stays modeled on Medicare Advantage practices;
  - Studying the relationship between IRF PPS payment rates and costs and seek legislative authority to make any changes necessary to more closely align them; and
  - Considering the high error rate found in this report and CERT reviews in future acute inpatient rehabilitation service payment reform, which may be a component of a unified post-acute care PPS system.

PRACTICAL TAKEAWAYS

Because OIG audit revealed such a high IRF payment error rate, we can expect that at some point CMS will act in accordance with OIG's recommendations.

IRFs, including free-standing rehabilitation hospitals and rehabilitation units embedded in acute-care hospitals, should act now to ensure that they are meeting the Medicare coverage and documentation requirements set forth above. For example, patients with generalized weakness, overall fatigue and impaired mobility, for which appropriate therapy could be regular activities such as walking and general exercise, were determined by OIG not to meet IRF coverage requirements. Patients who were unable to tolerate intensive rehabilitation and demonstrate measurable improvement of practical value also were deemed inappropriate for IRF admission and coverage. IRFs should consider these clinical scenarios and others identified in the Report[1] prior to approving IRF admissions.

As to inadequate documentation to justify payment for an IRF stay, this can be rectified by working with IRF physiatrists (i.e., rehabilitation physicians) to ensure they both understand the requirements and follow through with appropriate documentation.

When an IRF receives notice of a payment denial or overpayment, it should work with experienced counsel to determine if legitimate

grounds for appeal exist.

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[1] See Coverage Requirements Not Met section of Report on pp. 8-9.