

**CMS**

**Moderator: Robin Phillips  
February 23, 2005  
12:30 p.m. CT**

Operator: Welcome to this Inpatient Rehabilitation Contractor Training conference call on CR 3334, CR 3503, 75 Percent Rule Clarification. All lines will remain in a listen-only mode, until the question-and-answer session. At that time, if you have a question or a comment, simply press star one on your touch-tone phone. Today's conference is being recorded. If anyone has any objections, you may disconnect at this time.

There will be a rebroadcast of today's call starting at 5:30 PM eastern today. The dial-in numbers are: 719-457-0820 and 888-203-1112. Please enter the pass code of 3848601 pound. I will now turn the conference over to Robin Phillips, please go ahead.

Robin Phillips: Hi. Thank you, Gwen. This is Robin Phillips. I'm with the Provider Communications Group Division of Provider Information Planning and Development at CMS in Baltimore. I would like to welcome to everyone to our IRF provider education conference call that will focus on CR 3334 Medicare IRF Classification Requirements, CR 3503 Inpatient Rehabilitation Facilities Classification Requirements, including section 412.23b2 and the procedures used to determine compliance with the 75 Percent Rule.

The purpose of this call is to discuss verification procedures for the 75 Percent Rule, not to debate the policy. We would like to get your feedback about today's call. We have an online

evaluation form that can be completed and submitted quickly. The form is titled Training Evaluation Form, and it can be found at [http://www.CMS.HHS.gov/medlearn/cont\\_eval\\_form.asp](http://www.CMS.HHS.gov/medlearn/cont_eval_form.asp). And we look forward to hearing your comments.

I would also like to let you know the Medicare contractors Central Office, Regional Office staff have been invited to listen to our call today. Today's call is being recorded and transcribed. So please identify yourself before you speak.

At this time, I would like to have everyone in the room here at CMS in Baltimore introduce themselves, and say what component or division you are with.

Bob Kuhl: Bob Kuhl, Division of Institutional Post Acute Care.

Julie Stankivic: Julie Stankivic, Division of Institutional Post Acute Care.

Terrie Black: Terrie Black, IRF PAI Help Desk.

Peter Diaz: Peter Diaz, Division of Institutional of Post Acute Care.

Karen Pardue: Karen Pardue, Provider Communications Group.

Robin Phillips: Thank you. I would also like to let everyone know that if they're having trouble downloading the PowerPoint slides, the slides can be found on the UDS website. That is [www.UDSMR.org](http://www.UDSMR.org).

At this time, I would like to turn the call over Pete Diaz for the presentation.

Peter Diaz: Thank you, Robin. And I'm going to go ahead and repeat that website that Robin just

mentioned in case some of you didn't have a chance to write it down, in case you did – were not able yet to download the slides from the CMS website. The website that Robin just mentioned is [www.UDSMR.org](http://www.UDSMR.org). So in case you still need to get the slides, quickly, you can go to that website.

For those of you that do have the slides, you know that the first slide just has my name and my title which is the Inpatient Rehab Facility Prospective Payment System Team Leader.

I'm going to be talking quickly, because I'm going to be assuming that you do have the slides, and you can read from the slides. I'm going to explain a little bit about the slides, but I'm going to be talking quickly, because I want to allow as much time as possible at the end of the call, for questions-and-answers. There will be another call in the future. There will be more or less a repeat of today's call. And we will also try at that point, to allow even more time for questions-and-answers.

So for those of you who do have the slides, I'm on slide number two. And slide number two just says the 75 Percent Rule. It mentions the regulation (412.23(b)(2)). There is – I see a typo there that says 239. It should be .23(b)(2).

The following print on that slide says "New" IRF Unit Versus Converted Unit, and that's (42 CFR 412.30) and Changes in the Status of a Hospital or Hospital Unit, which are two different regulations, (42 CFR 412.23(i) and 42 CFR 412.25 (c) and (f)), C like in Charlie. The reason I'm going to be talking about these other regulations, briefly, is they do have a relationship to the 75 Percent Rule.

I'm on slide number three, and slide number three is entitled General Legal Background. I'm not going to read everything that's on this slide. It basically has the General Legal Background that we published in either one of two places. We published this General Legal Background as part of

our regulations, in other words, when we publish Federal Register documents that are called either proposals or final rules, we do give the statutory basis for our rule making. And so this information is coming from those documents. There is one statutory site under the General Legal Background and that's section 1820(c)(2)(E) of the Social Security Act. And that addresses what's called a CAH, a CAH is a Critical Access Hospital, and the fact that they can now have a distinct part unit. And a distinct part unit, may be a rehab unit. That statutory site comes from the survey and certification letter that dealt with critical access hospital distinct part units. If you want to get a copy of that it is up on the CMS website. It's up on the, what's called the CMSO website. And you'll have to go to several links to finally obtain it, but it is up on the CMS website. And you can see what it has to say about critical access hospital, distinct part units, and those that are either rehab units or even psych units.

I'm on slide number five entitled IRF Classification Requirements, and it states in order to be classed in IRF our facility must first meet the requirements that we classify as an acute care hospital, acute care unit, or a critical access hospital. As the facility meets the requirements to be classified as an acute care hospital, acute care unit or a critical access hospital, it must meet several additional requirements, in order to be classified as an IRF.

And that's important to know because the 75 Percent Rule is only one of the requirements that a facility must meet to be classified as an inpatient rehab facility. There are many other requirements. Those other requirements can be found in the CR program transmittals that were mentioned previously. And when you look at those other requirements, you'll actually note, those of you that are familiar with the code of federal regulations, that they're coming really straight from the regulations themselves. Many of them are word for word from the regulations.

42 CFR 412.23(b)(2), which is commonly referred to as the 75 Percent Rule and that's how I'll refer to it as I continue to talk to during this presentation, is one of the requirements that a facility must meet to be classified as an IRF.

I'm on slide number six. What is the Compliance Percentage Threshold? This is a phrase that you'll find in the documents that we published, either the Federal Register documents, or the change request. What I'm referring to is the CR's, that are also called program transmittals. And the compliance percentage threshold is a percentage of the IRF's total population that must match one or more of the 13 medical conditions specified in the regulations.

The percentage is referred to as the compliance percentage, and if the IRF meets the percentage, it has met the compliance percentage threshold. The compliance percent threshold requirement for cost reporting periods, beginning on or after July 1, 2004 and before July 1, 2005 is 50 percent. That's the period we're in right now. The cost reporting period is beginning on or after July 1, 2005 and before July 1, 2006. The compliance percentage threshold 60 percent, and for cost reporting periods beginning on or after July 1, 2006 and before July 1, 2007, it's 65 percent. The cost reporting period beginning on or after July 1, 2007, the compliance percentage threshold is 75 percent. Once again, this directly from the regulations.

I'm on slide number eight. The slide is entitled Which are the Medical Conditions Used to Determine Compliance with the 75 Percent Rule? I am not going to read these 13 medical conditions. They're in the regulations. They're in the CR's. It would be very lengthy to read these medical conditions over this – in this presentation. And like I said, we're trying to allow as much time as possible at the end for questions-and-answers. But you can see what they are, they're detailed in slide eight, nine, 10, 11, and 12.

On slide number 13, Which are the Medical Conditions Used to Determine Compliance for 42 CFR 412.23(b)(2)? For cost reporting periods prior to July 1, 2007, patients admitted for inpatient rehabilitation for a condition that is not one of the conditions specified above, in other words, one of the 13 medical conditions, may be included in the percentage threshold if a patient has a comorbidity that matches one of the conditions specified above and the comorbidity caused

significant decline of functional ability in the individuals, such that even in the absence of the admitting condition, the individual would require, the intensive rehabilitation treatment, that is unique to inpatient rehab facilities paid under the IRF PPS. This wording is from the preamble of the final rule that we published on May 7th, 2004.

What it's saying, briefly, is we will count towards meeting the compliance percentage threshold a medical condition that's one of the comorbidities specified either in the medical record or the PAI data form that's filled out. However, that comorbidity must be such that it causes a functional decline of functional ability. And such that even in the absence of the admitting condition, the individual will require the inpatient rehab treatment that is unique to inpatient rehab facilities on the IRF PPS.

Reasons for the Use of the Term "Presumptive". This question comes in frequently. People have asked why do you term one of the two methods that you use to verify compliance, one of them is termed the presumptive method. Those of you that have read the CRs know that CMS will use two methods to determine compliance with the 75 Percent Rule. The first one is a method that's software driven, computer software driven. The second method is the old method, which is the reading of medical records. The first method is termed presumptive, for a number of different reasons that I'm about to state. And I think after I give you the rationale of why we use the term, you'll understand it, but it is – this is on the slide, I'm reading it right from the slide.

OK. The five reasons. The determination methodology applied during the presumptive method is applied only to the Medicare part A fee-for-service portion of the IRF's total inpatient population, not the IRF's total inpatient population. The regulation actually reads that if the IRF's total inpatient population that must meet the compliance percentage.

However, the first method that we're using since it only uses that PAI data form, and that data form must only be filled out on Medicare Part A fee-for-service, that's the only data available. So therefore, we don't have data from the PAI – using the PAI form for private paid patients,

Medicaid patients, charity cases, workman's comp patients, or any other type of patients that are part of that inpatient rehab facility total inpatient population.

So we're making an assumption. We're making an assumption when we use the presumptive test that uses only PAI data that that population, that Medicare part A, fee-for-service population does reflect what the total inpatient population is. Now we're making that assumption based – if the FI can determine that the Medicare Part A fee-for-service population is at least 50 percent or more of the IRF's total inpatient population.

There was also research that was done, years ago, indicating that many of the conditions that are present in the Medicare Part A fee-for-service population, are truly reflective of the medical conditions of the total populations. It isn't a perfect one to one correlation, but it's very close to it.

The second reason why we use presumptive, in general, initially CMS does not know if the codes recorded on the IRF-PAI reflect the patient's actual medical condition. Let's face it, an inpatient rehab facility is filling out that form. They're sending in information. A lot of that information are codes either for the impairment group or the comorbidity or the etiologic diagnosis. Until we actually have somebody verify that those codes actually reflect what the patient has we don't know for sure if somebody hasn't made a clerical error, a deliberate attempt to fraudulently send in data. We don't know, really, if those codes are actually reflecting what that patient has. So we're making that presumption, but we reserve the right to check later on to see if what's being represented on that (PAI) data form actually reflects what the patient has.

Reason number three, the codes on the PAI data form, do not indicate if the therapy requirement for what we call the arthritis like conditions was met. Early on, one of the slides – several of the slides had the medical conditions. Medical conditions, 10, 11, and 12 are the ones that we call the arthritis like conditions. In order to – in order for those arthritis like conditions to be counted

towards the compliance percentage there is a therapy requirement that must be met. However that therapy requirement cannot be captured by use of the codes.

So once again, we're making the presumption that if one of the codes indicates one of those arthritis like conditions, that that therapy requirement was met, but we don't know for sure. And that's we give the FI the discretion to look further, even if an IRF meets the compliance percentage based on the presumptive method.

Reason number four, the codes do not indicate if the time requirement for the knee or hip joint replacement condition was met. And reason number five, the comorbidity codes do not indicate if the comorbidity being included in the compliance percentage determination, meets the requirement specified previously. In other words, functional ability and the things I mentioned before. So that's why we use the term presumptive. We are making an assumption that when we use the presumptive method for verification that certain things or more less were met. But we're not sure and we reserve the right to look further.

I'm on slide number 16, How will CMS Determine compliance with the 75 Percent Rule? Number one, by the fiscal intermediary using software that will allow the fiscal intermediary to make a presumptive determination regarding if the facility met the compliance percentage threshold, what I just mentioned. And number two, by the fiscal intermediary reading a random sample of selected portions of individual medical records, to determine if the compliance percentage threshold was met.

We did – I did specify in the CR's that certain portions of the medical records, the FI's should look at, gave examples. However, the FI is not limited to using only those portions of the medical record. They could get additional information. They could use other parameters. What we don't want the FI's to do is simply to get a code list from the inpatient rehab facilities and use that to quote unquote read medical records and make a determination that way.



We want the FI staff to actually read like admission notes, discharge notes, progress notes, from the RN from the PT from the OT staff. Maybe copies of admission orders, what have you. Something that gives a picture of what that patient had, or what the patient was there for, and what type of treatment the patient received, so that the FI staff has some sort of picture of that patient, and could make a determination whether that patient actually meets one of those 13 medical conditions.

How is the Presumptive Method Performed? I mentioned about the FI first determines is at least 50 percent of the facility's total inpatient population is composed of Medicare Part A fee-for-service patients. If that first standard is not met, the presumptive method cannot be used for that particular IRF. It doesn't mean it can't be used in the future or say in a future year, it just means in this particular year, in that particular year it could not be met.

So if that first standard is met, then the presumptive methodology uses a computer program that produces an electronic report from the IRF records and the IRF database. These are the records – these are the IRF-PAI data records that that IRF has already submitted to the database as part of a normal operating system of the IRF PPS.

The fiscal intermediary will access, what's called the QIES website, and using that website the fiscal intermediary will generate the report. I'm going to go back to that point in a moment and mention something.

Number four on the list, the report will have two columns, each showing a percentage of the IRF's Medicare Part A fee-for-service population that matched at least one of the medical conditions specific on the regulation.

The impairment group code, etiologic diagnosis codes, and comorbidity codes specified in Appendix A of program transmittal 347, which is change request 3503, were used to develop the computer program. And in general, if an IRF PAI data record has an impairment group code or etiologic diagnoses code, or a comorbidity code that matches one of the codes specified in Appendix A, that patient is presumptively counted as meeting the compliance percentage.

Specific impairment group comorbidity, and etiologic diagnosis, ICD-9 codes were excluded from Appendix A for certain medical conditions, because it was determined by the physicians here at CMS in consultation with some of other physicians, that review of the medical record was more appropriate than the use of codes under the presumptive test methodology.

So now we'll go back to one of these points I just made. And I wanted to mention now, there was – CMS recently put something up on the IRF PPS website that really should have only gone to the contractor website. It's not confidential information in any sort of way. It's not a mistake in that sense. We wrote what I term a quick and easy way of the FI being able to access the QIES website. And we wanted to put that on the contractor website. And by accident that was put on the IRF PPS website. Don't try to use that method to get into the QIES database. The reason is you need a password in order to access that database, in order to get that password, you have to fill out a very specific form, and answer quite a number of questions. And that has to be sent to another contractor. And then, they're the ones that verify that information to actually issue the password.

We do not plan or we will not be giving out passwords to individual IRF's to be able to access that database. That database has information about all of the inpatient rehab facilities. For nothing else, for privacy concerns, we will not give access to any IRF to access the database to have information about every IRF in the nation.

I'm on slide number 21 now, which is titled, What Other Method is Used to Determine the Compliance Percentage? The fiscal intermediary will read a random sample of some parts of a patient's medical record. The random sample is selected from the entire inpatient population of the IRF. The fiscal intermediary has discretion to use a variety of methods to determine if a patient's medical condition matches one of the medical conditions listed on the regulation. Reading a random sample of some parts of a patient's medical record results in a more accurate determination if an IRF met the compliance percentage threshold.

Slide number 22, excuse me, in general, the FI always has discretion. Now let me state that again, in general, the FI always has discretion even if an IRF using under the presumptive methodology met the compliance threshold. The FI always has discretion to include a patient in one of the medical conditions listed in the regulations based upon a review of the clinical record, regardless of the presumptive test methodology above. Therefore, under the presumptive methodology the IRF may meet the compliance percentage –oh, I'm sorry-therefore, although under presumptive methodology the IRF may meet the compliance percentage the fiscal intermediary can always read a random sample of the entire inpatient population of some parts of a patient's medical record, to determine if the compliance percentage was met.

So in a nutshell, we gave the FI's two ways to determine compliance. Even if under the presumptive tests an IRF meets the compliance threshold, the FI, if the FI wishes, it's their option, can choose to go further. If they have some other indications that maybe indicates they need to get a random sample of medical records, and do the compliance determination using that method, they have the discretion to do that.

What is the Compliance Review Period? This is the time period from which data will be selected to make the compliance percentage determination. In general, the compliance review period is 12 months. However, in certain situations it's less than 12 months. In the CR's that we published there is a table that gives the compliance review period, if an IRF's cost reporting period starts a

certain month and year. I think everybody has seen that table. We recently put on the IRF PPS website, a document called fact sheet number two. Fact sheet number two is entitled Compliance Threshold, Percentages Associated with the Compliance Review Time Period.

We put this fact sheet up in order to try to clarify more what will be the compliance percentage threshold, associated not only with a complete compliance review period, but in certain cases, with portions of a compliance review period. And we gave in that – in the table and fact sheet number two, we gave the actual percentage amounts that would be associated with a compliance review period, or portions of a compliance review period. This is because questions were asked “what happens when a compliance review period spans two cost reporting periods?”

I’m on slide number 24, Relationship of the Cost Reporting Period to the Compliance Review Period. The cost reporting period establishes the compliance percentage that must be met. The compliance review period establishes which time period will be used to select the data that will determine if the compliance percentage was met for a specific cost reporting period.

Slide number 25 is the generic version of the report that the fiscal intermediary will produce when they’re using the presumptive method. It shows you some of the – well it shows you the information that the FI will see. What it doesn’t have on the slide is the methodology that the FI needs to use in order to come up with a percentage method in certain cases. If you want to talk about that – what method the FI would use in a particular case, I encourage you to talk to your particular FI.

Slide number 26, Failure to Meet the IRF Classification Requirements. There are a couple of regulations that are mentioned in this slide. And those regulations basically state that the – a change in the classification status of an excluded hospital unit or unit of a hospital is made only at the beginning of a cost reporting period.

When we use the term here, excluded hospital, or hospital unit, what we're talking about is a hospital or hospital unit that's excluded from what is called the inpatient perspective payment system, the payment system that's normally known as the DRG payment system.

Failure to meet any of the requirements to be classified as an IRF results in the facility being paid under the inpatient perspective payment system, or as applicable under the payment system Medicare uses to pay a critical access hospital, if the facility meets all applicable Medicare certification and state licensing requirements for either of these other payment systems.

So if you lose your status as an IRF, and let's say you would be paid normally under the inpatient perspective payment system, you still have to meet all of the requirements to be paid under the inpatient payment system, otherwise, Medicare won't pay you under that payment system either.

The Effect of the Consolidated Appropriations Act, 2005, on the Revised Classification Requirements for IRFs. Many of you know that recently there was a law passed, a Consolidated Appropriations Act 2005 that directed CMS to do certain things.

In a nut shell, CMS may not change the classification of facilities that were classified as IRF's as of June 30th, 2004 until CMS either, one, determines that our current regulations at 412.23(b)(2) are not inconsistent with a soon-to-be-released Government Accountability Office IRF study. And that report still has not been released by the GAO. And number two, in accordance with the provisions of a soon-to-be-released GAO IRF study, issues an interim final rule revising the criteria 412.23(b)(2) used to classify a facility under an IRF.

So if you were classified as an IRF on or before June 30th, 2004, for now, CMS cannot change your classification even if you were to fail the requirements for the 75 Percent Rule. And the requirements for the 75 Percent Rule, we have other requirements. What – that's what we put in place very recently, pending the release of the GAO report.

Now once the GAO report comes out, and there's a determination made that the recommendations in that report are not inconsistent with our regulations, we will at that point, of course, lift that moratorium, what we call moratorium enforcement, and everything was just like it was previous to us issuing that moratorium.

The other thing to note is that moratorium only applies to not meeting the 75 Percent Rule requirement. If you don't meet the 75 Percent Rule requirement, we can't change your classification until we lift that moratorium. However there – I mentioned earlier that there are many other requirements. If you don't meet one of these other requirements, we can now – we can and will change your classification from being an IRF to another type of facility. Because the law was specific to the 75 Percent Rule requirement, not to the other requirements that IRFs are to meet. So when you look at this slide, and you're reading this information, and read it very carefully.

Because of that, the FI's will continue to perform the compliance review on all IRF's. However, until further notice from CMS Central Office, CMS Regional Offices will not make any changes to the status of a hospital or unit of a hospital that is classified as an IRF, on or before June 30th, 2004, and fails to meet the requirements specific on 412.23(b)(2). Notice that it says there CMS Regional Offices. It's the CMS Regional Offices that eventually make that determination. The FI makes a determination regarding whether a facility did or did not meet the 75 Percent Rule. But the Regional Office is getting information from other state agencies and in a couple of cases right from the IRF itself. So it's the Regional Office that has the information from a number of different places, to know if all of the requirements were met. And that's why its the Regional Office that must make the determination, and advise, both the FI and the inpatient rehab facility as to whether – for its next cost reporting period, the inpatient rehab facility will or will not be considered an inpatient rehab facility to be paid under the IRF PPS.

For a hospital unit or unit of a hospital that was classified as an IRF after June 30th, 2004 and fails to meet 412.23(b)(2) or fails to meet any other requirements specified in sub part b of part 412, the Regional Office will terminate the facility's classification as an IRF. Please note an IRF, including facilities classified as IRF's on or before June 30th, 2004 that fails to meet any of the other requirements to be classified as an IRF specified in sub part b, of part 412 will have its classification as an IRF terminated.

I'm on slide number 30. It mentions that there are some other additional IRF requirements that IRF's sometimes overlook. What's a "new" unit versus a converted unit 412.30 specifies the requirement to be classified as a new unit. They're right there on the slide.

Slide 32 new unit versus converted unit. It's the CMS Regional Office that makes the determination if the requirements in 412.30 were met. If an IRF is classified as a new facility under the regulations, it can self-attest that it will meet the requirements of the 75 Percent Rule. However, the FI will later determine if those requirements were actually met. And a unit undergoing the conversion process to become an IRF must meet the requirements of the 75 Percent Rule during the conversion time period. So that's a big difference. If you're undergoing conversion, you've got to meet the 75 Percent Rule during that conversion process for a certain period of time. Before you can officially be called an IRF and be paid under the IRF PPS, if you're classified as new from the beginning, you can just attest that you're going to do that for the following period, and be paid under the IRF PPS immediately.

However, if you fail as a new IRF to actually meet yourself at the station statement, what the FI will do we'll go back and recalculate your claims and more than likely ask you to – and say that we paid you too much, because you really didn't meet the 75 Percent Rule and this is what we would have paid you under the IPPS and do that type of conciliation of the – reconciliation of the claim amounts that were paid.

The last slide, it's already 2:20, the last slide is when changes in the status of a hospital, a hospital unit may occur. There's a couple of regulations that are mentioned on the slide. The change in the classification of a unit from "not excluded from the acute care hospital inpatient perspective payment system" to "excluded" may be made only at the start of a cost reporting period. This requirement causes problems for facilities because they start making some changes in some sort of way that they want to have that particular unit, classified as inpatient rehab facility.

But in order to do that, there's a certain amount of paperwork that must be submitted to the Regional Office or some other requirements that must be met. And because of that, that takes time. So if the inpatient rehab facility doesn't start doing that in sufficient time, the cost reporting period time will come up, and they won't have finished doing everything that they need to do, and they're going to have to wait to the next cost reporting period starts, in order to have that let's say hospital unit classified as an IRF.

So in other words, at these two regulations, 42 CFR 412.23(i) and 42 CFR 412.25(c) and (f), C like in Charlie and F. And talk to your Regional Office staffers if necessary, talk to them, don't talk to the FI initially because you're going to have initiate this type of paperwork, first, with your Regional Office. And realize how much time you need to have before your next cost reporting period starts, so that everything can be done on time, so when your next cost reporting period starts you can have the appropriate change made.

About once a month we get calls here in Central Office and we redirect them back to the Regional Office, because some facility has started to do something, wasn't aware of this regulation, and they're not able to do what they wanted to do in the time period that they wanted to do it.

Slide number 34. The change from excluded from the acute care, so in other words, you're already excluded from the acute care hospital inpatient payment system for not excluded, may be made at any time during a cost reporting period, if the CMS Regional Office and facility and the



facility's fiscal intermediary are notified in accordance with the notification requirements in the regulation.

What's on page 33 and 34, it looks like it's the same, it's not. Look at it over very carefully. See – look at the wording. This wording comes right from the regulations. You need to examine it and see that the meaning is actually different on these two slides and see which one applies to your situation or might apply to your situation in the future.

OK, I managed to talk very quick. I hope I didn't talk too quickly to confuse some folks because I said I want to try allow as much time as possible for questions and answers. At this point, I'm going to turn it back to Ms. Phillips and for her to continue with the presentation.

Robin Phillips: Thank you, Pete. We will now open the call for questions, but before we do, I'd like to remind you that this call is being recorded and transcribed. So please give your name and tell us what organization you're with. In an effort to get as many questions as possible, we ask that you limit your questions to one. We hope we have enough time to ask everyone – to answer everyone's questions today.

Operator, at this time, we'd like to open the call for questions.

Operator: Thank you. If you would like to ask a question, please do so by pressing the star key followed by the digit one on your touch-tone telephone. If you are using a speakerphone, please make sure your function is turned off to allow your signal to reach our equipment. Once again, star one if you have a question. We'll pause for just a moment to give everyone an opportunity to signal.

And we'll go first to Michael Butts with HCA.

Michael Butts: Hi, Pete. This is Michael Butts with HCA. I've got actually a couple of questions, but I'll call back in with the other one. The first one is nowhere in any of the change requests has there been a definition of the prior levels of care. And my question specifically relates to the acute care setting, does that count towards prior outpatient – prior therapy?

Peter Diaz: Now what do you mean by prior levels of care, Michael ...

Michael Butts: Well when you're talking about the requirements for the arthritis patients, they have to have a prior course of treatment for therapy that's documented that has actually failed. And so I've had many of my facilities ask does this include acute care, so that a patient has received therapy in an acute care setting, and that has failed, and then they move to the inpatient rehab unit. Would that qualify that patient for one of the arthritis categories?

Peter Diaz: The only stipulation for the arthritis like conditions, and it is mentioned in the CRs because the CRs just as far as the medical conditions, are the same medical conditions on the regulations. It does talk – and I know you're aware of this, about having a certain amount of therapy, a certain amount of group therapy, individual therapy, a certain amount of time before you're admitted to the inpatient rehab facility. And that's all it mentions.

As I recall it doesn't have in there, and I would have to look at the specific wording. It doesn't have in there as to the site, let me see – no it does. It says very clearly, they have not improved that's an appropriate, aggressive and sustained course of outpatient therapy services, or services in other less intensive rehab facilities. Rehabilitation starting immediately proceeding the inpatient rehab admission.

So it does address the type of studying that – where the therapy should be performed at.

Michael Butts: So does acute care count in that other level of care setting?

Peter Diaz: Yes, I would say it counts, because we consider the acute care setting to be less intense than the inpatient rehab setting.

Michael Butts: Good. I'm glad you said that. That's what I've been telling my folks too. Thank you.

Operator: We'll go next to James Kanuch with Allegheny General Hospital.

James Kanuch: Yes, my question is if the compliance for the Medicare fee-for-service is not met, but the threshold for the all payers is met, what are the implications?

Peter Diaz: I'm sorry, could you repeat your question, please?

James Kanuch: Sure, the question is you mentioned before about the Medicare fee-for-service, if that compliance level is not met, the implications associated with the program. But if the – if all payers, the threshold is met for all payers what happens at that point?

Peter Diaz: OK. The thing about the Medicare Part A as opposed to all payers is first a determination must be made by the FI as to whether the Medicare Part A fee-for-service portion of the inpatient population is 50 percent or more. OK, if that standard is met, then the FI can use the presumptive method.

If that standard is not met then the FI must go to the second method, which is using the total inpatient population. And one of the things that is stated in the CRs is, initially the FI has to go and get information from the inpatient rehab facility to make that determination. The FI is going to obtain information from the inpatient rehab facilities. They'll let them determine what was the total number of inpatients during a certain period of time, what were the payer or payers for each one of those patients and so on.

So at that point, if the presumptive method could be met – can be used if the standard is met at 50 percent or more, as I mentioned before, the FI can use presumptive method. If not, then it's every patient in the rehab facility becomes part of the patient – is part of the patient population. And the FI obtained a random sample from that total inpatient population, regardless of what the payer source is. So in other words, during a random sample of let's say we have 1,000 patients.

I'm just taking this from the top of my head. This is not necessarily a member for a random sample. But let's say there's 150 patients or so, in that random sample, some of those patients in that random sample, might be Medicare Part A, might be Medicaid patients, might be prior to pay, might be charity cases, might be workman's comp cases. Does that answer your questions?

James Kanuch: Yes, it does. Thank you.

Robin Phillips: Thank you, James. We're ready for the next call, Operator.

Operator: We'll go next to Maggie Moor with Washoe Rehabilitation Hospital.

(Hayden Hill): Hi. This is (Hayden Hill) at Washoe Rehab in Reno. The question is pertaining to slide number two on the third page about the conditions that comply with the 75 Percent Rule. And specifically to poly neuropathy. I'm a podiatrist and I've seen language before or some communications before that said alcoholic peripheral neuropathy may qualify, but diabetic peripheral neuropathy may not.

And I'm a little confused as to the etiology of the neuropathy whether that would qualify or not it seems that it's the impact on the functional ability or ability to function of the patient, that should be the key criteria. Could you address that please?

Peter Diaz: Well first of all where did you say you say some information. Where did you see this information because that information did not come from here?

(Hayden Hill): OK. Communications we've received from the different professional rehab organizations. And maybe I misunderstood it, but it appeared that poly neuropathy from one diagnosis may qualify, but from another may not. I apologize if I misunderstood.

Peter Diaz: OK. Firstly, I wanted to clarify that. What I stated earlier was the, the fiscal intermediaries have discretion to make a determination as to whether a particular medical condition that a patient has meets one of those 13 medical conditions.

That's exactly what I meant. When I mean has discretion, I meant that the FI medical staff there whether its physicians, or registered nurses or OTs or PTs or a combination of would make a determination whether a patient with a particular medical condition, one of these neuropathy's that you mentioned, meets one of those medical conditions.

You'll have to speak to your particular FI about that, because since we gave them discretion to make that decision, those are the folks that will be making decision on the type of case that you just mentioned.

(Hayden Hill): OK. Thank you. So as I understand it, we would clarify that with the fiscal intermediary.

Peter Diaz: That's correct.

(Hayden Hill): But the position of the Central CMS Offices, you do not by definition exclude in or out different diagnosis that cause that peripheral neuropathy, is that correct, sir?

Peter Diaz: I have not heard anything from the physicians about that one way or the other. Anything that they would put out would be put out officially or CMS type policy, so that's why I asked where you got information because I haven't seen anything like you mentioned coming out of this building.

(Hayden Hill): Thank you very much, sir.

Operator: We'll go next to Joe Maese with Methodist Healthcare Systems.

Joe Maese: Hello?

Robin Phillips: Hello.

Peter Diaz: Hello.

Joe Maese: Yes, this is Joe Maese with the inpatient rehab center at San Antonio for the Methodist Healthcare system. (Merrill) and I were here, and we had a question regarding the...

Merrill: The presumptive Medicare A, and commercial, and it was already answered. It was the first question, I think.

Peter Diaz: OK. Do you have another question?

Joe Maese: No, I think it was already answered in previous questions. Thank you so much.

Robin Phillips: OK. Next call, please. Next question.

Operator: If you do find that your question has been answered, you may press the star key followed by the digit two to remove yourself. And we'll go next to Marsha Wolske with Grand ITASCA Clinic and Hospital.

Marsha Wolske: Thank you. This is Marsha Wolske calling from Grand ITASCA Clinic and Hospital in Grant Rapids, Minnesota. And I just have a question. As a new inpatient rehab facility we are part of UDS pro, and my question is if I am submitting, transmitting data through UDS pro, will our FI just use that already transmitted information? Or is the determination going to be based on a different report that I'll need to be submitting? And will that be electronic? Will it come to me hard copy? What can I expect as far as insuring that the FI gets the information they need to make our presumptive determination?

Peter Diaz: OK. And this applies to others, also. There are a number of different software systems on the market that an IRF can use to transmit it's IRF PAI data. UBS PRO is one of those. There's (e-rehab data). There's a number of other systems. We put out the basic system upon which these other systems are based, which is called the (Urban).

If you're transmitting your IRF PAI data using the (Urban) system, the UBS PRO system, the (e-rehab data) system or any other system, eventually it all goes to the same place and that's to the Iowa foundation for medical care, that's where the IRF PAI database is housed.

So you don't have to worry about sending your data in any other sort of way. When you're transmitting using that system, your PAI data should be coming into our database. You should be receiving, in fact, a transmission a validation report. You should be receiving a preliminary report and then a final report. Are you receiving those types of reports?

Marsha Wolske: Yes.

Peter Diaz: OK. Well then that's validation that your data was transmitted, was accepted, or some sort of problem was – developed, you would see that in the report.

Marsha Wolske: OK. And so, again, to conclude the FI will make our presumptive determination based on that data that I've already submitted. Don't worry about completing any other report?

Peter Diaz: That's correct. Now I'm going to use your question – did I answer your question, first of all, forward?

Marsha Wolske: Yes.

Peter Diaz: OK. I want to use your question to go to one other point. And that is this, in the CR's that we publish, there's an Appendix A. There's a listing of codes. There's a listing of impairment group codes. There's a listing of etiologic diagnosis codes, and comorbidity codes.

Those codes are the codes that are going to be used to determine under the presumptive test, whether out of the universe of the PAI data records that an IRF submitted to our database, whether a certain percentage of those records meet one or more of these 13 conditions.

Somehow, earlier on, and I hope this confusion is no longer there, but just in case. Some folks were thinking that they should use Appendix A, the codes that are on the CR, Appendix A, to actually code the IRF PAI assessment instrument. That is not the case.

As far as the IRF PAI assessment instrument itself, you are still to use the instructions in the IRF PAI manual. That manual has a number of Appendixes. One of those appendixes is Appendix B. That Appendix B does impairment group codes, and etiologic diagnosis codes, and some other codes in there.



At any rate, use the instructions in the IRF PAI manual when you're coding the assessment instrument. Don't try to code your assessment instrument from Appendix A of the CR's.

Marsha Wolske: Can I just add the IRF PPS website address? Could you repeat that for me?

Peter Diaz: The IRF PPS website?

Marsha Wolske: Yes.

Peter Diaz: The main website?

Marsha Wolske: Yes.

Peter Diaz: OK. Let me go from memory, I don't have it in front of me, but it should be  
[www.cms.hhs.gov/providers/irfpps...](http://www.cms.hhs.gov/providers/irfpps...)

Marsha Wolske: IRF PPS?

Peter Diaz: Right, for inpatient rehab facility prospective payment system, all connected, /default.asp.

Marsha Wolske: Default.asp.

Peter Diaz: Right.

Marsha Wolske: Thank you very much.

Peter Diaz: You're welcome.

Operator: We'll take our next question from Chad Deardorff with Weslaco Rehabilitation Hospital.

Chad Deardorff: Yes, hi, this is Chad Deardorff with Weslaco Rehab Hospital. My question is for a brand new free standing IRF that was certified by Medicare as a free standing IRF after July 1, 2004, and has a Medicare cost reporting fiscal year that is June 1 through May 31. First of all, does today fall under 50 percent compliance immediately?

And second of all, does it fall in to the table that you set forth in the fact sheet number two for existing facilities for compliance review period purposes? So for us, four months prior to that, we would start February first of '05, under 50 percent.

Peter Diaz: OK. All I need to ask you, once again, is when does your cost reporting period start?

Chad Deardorff: Our cost reporting period starts June first, but we were not certified in the Medicare program as a free standing IRF until after July 1, 2004. So we haven't had a full year – fiscal year – full year cost reporting year, yet.

Peter Diaz: OK. So your first cost reporting period started on June 1, 2004, correct?

Chad Deardorff: No. Because we weren't certified until October.

Peter Diaz: OK.

Chad Deardorff: But our Medicare fiscal year will be – is June first. So our first cost reporting period is going to be October 7 through May 31.

Peter Diaz: OK, so your cost reporting period starts on October the seventh?

Chad Deardorff: For the first one. But the first full year cost running period will start June 1, 2005.

Peter Diaz: Right. OK. But the very first one started on October the seventh?

Chad Deardorff: Yes, sir.

Robin Phillips: OK. So go to the table where you see, you know, the listing of cost reporting periods, and yours doesn't start right on the first of October of 2004, yours starts on October the seventh. So your compliance review period is not exactly as listed in the table. The compliance review period for the cost reporting period that starts on 10-1-2004 is 7-1-2004 to 5-31-2005. Your cost reporting period instead started 10-1-2004 you said, but your next one would start on the June the first.

Chad Deardorff: Correct. So my question basically – I think I've read that it does start immediately under 50 percent. But my real question is do – once we get towards the – will we fall in to the table of existing facilities that you set forth for say for our cost reporting period that is June 1, 2005 through 5-31-06, then is our review period going to start on that February 1, 2005?

Peter Diaz: OK. If your next cost reporting period starts on June 1, 2005, that's what you're saying, right?

Chad Deardorff: Correct?

Peter Diaz: OK. All right, if you're next cost reporting period starts on June 1, 2005, we have to allow the Regional Offices and the FI's four months prior to the June 1, 2005 to do the work that they need to do in order to make a determination to see if your facility has met all of the requirements to be still classified as an IRF as of June 1, 2005.

So your compliance review period in the case that you mentioned is going to be a very short one. It's going to start from the time that you actually started your cost reporting period, and it's going to end four months prior to June 1, 2005. So let's see that would be...

Chad Deardorff: January 31, 2005. So basically we've had a review period of October 7, 2004 through January 31, 2005.

Peter Diaz: Right. In the situation that you mentioned. The only thing is what I'm wondering about, and you might want to check with your Regional Office, and your FI as to when officially your cost reporting period started because you mentioned also June '04 and you said we didn't meet our Medicare certification and such. And want – you know, you'd want to find out exactly when your cost reporting period started, because that's the trigger point on these compliance review periods.

If it's a case like you mentioned that it actually didn't start until October the seventh, what we just discussed would be the case in your situation.

Chad Deardorff: Well the other reason I say that the cost reporting period wouldn't start until October 7, 2004 and not 6-1-04 is because we weren't certified in the program. But Medicare has on file that our Medicare cost recording fiscal year is going to be June one. And so that's where I'm kind of having a little confusion with – I'm pretty sure that I interpreted to where the 10-7 through 1-31, we would have a review period, and that would be under 50 percent. But the part that I'm unclear about is since our cost reporting period, the next cost reporting period is going to start 6-1-05 if will stay under 50 percent for the timed period, the review period from February 1, 2005 through January 31st?

Peter Diaz: No. Because what's you're going to happen in your situation is, and then I'm going to have one of the staff members here that identified themselves earlier, say something Julie Stankivic. Your next cost reporting period starts on 6-1-05, OK.

What's going to happen in your situation is this, it isn't until 7-1-05 where the percentages changes from 50 to 60.

Chad Deardorff: Right.

Peter Diaz: Your cost reporting – if your next cost reporting period happened to start on 6-1-05, you're still under the situation that for cost reporting periods on or after 7-1-04 and before 6-30-05, the compliance percentage of 50 percent. So for your cost, if you indeed, have a next cost reporting period that starts on 6-1 you'll still be under 50 percent.

Chad Deardorff: OK. I just wanted to verify that. And then, from then on, we'll just – we'll be able to follow that table?

Peter Diaz: OK, right. Now hold on, Julie, you wanted to say something?

Julie Stankivic: The instructions for determining when your first cost reporting period can be found in the provider reimbursement manual. And I want to say it's section 201, but don't hold me to that, because it's been a long time.

But essentially, what it will tell you is that when you took your first patient in your IRF whether or not you were certified, that could have been covered by the program, that's when your cost reporting period will actually begin.

Chad Deardorff: OK. And provider reimbursement manual, you said, you think it's section 201, you said?

Julie Stankivic: I think it's 201.

Chad Deardorff: OK. You all have been very helpful, thank you very much.

Peter Diaz: Great.

Operator: We'll go next to Joanne Empie with Maria Perham Medical Center.

Joanne Empie: Hello. When you all were talking about the review period, I was referring back to the fact sheet, and it does say admissions or discharges. And so my question is, if we monitor based on admissions, and then, the intermediary comes back and monitors based on discharges, what are your thoughts on how we should be monitoring?

Peter Diaz: OK. No problem. We just last week issued a change request. Change request 3704 transmittal, program transmittal 478. That's change request 3704 transmittal 478. It is up on the CMS website for program transmittals. You can obtain it from there, download it, print it. What you'll – like said this has already been issued, but it's very recent.

We were concerned here about whether there should be admissions or discharges, that should be used for this verification. So we went to the Office of the General Counsel for the Department Health and Human Services to get our legal opinion, and they rendered that opinion.

The information you'll see in change request 3704 reflects the opinion of the Office to the General Counsel. What it said is that you as the IRF must tell your FI if you want, either the admissions or discharges during the compliance review period to be used to make this determination. You have a choice, one or the other.

Joanne Empie: OK. Very straight forward. Thank you.

Peter Diaz: OK.

Operator: We'll go next to Barbara Franklin with Sun Health.

Barbara Franklin: We have an existing IRF that is excluded from the hospital inpatient PPS. And we are considering relocating that on our campus, does – is there any restriction on the timing of that move, if it's an existing IRF?

Peter Diaz: I would say have you talked to the Regional Office about that and the FI?

Barbara Franklin: I'm sorry, could you repeat that?

Peter Diaz: Have you talked to your Regional Office, and FI about that particular move?

Barbara Franklin: We're in the process of communicating with them, yes, our entire plan.

Peter Diaz: And that would be the beginning point event starting any process as you just mentioned.

Barbara Franklin: OK. But from your perspective, if you're existing and you're excluded, is there any restriction on timing to move?

Peter Diaz: Not that we know of, but the Regional Office that handles these types of operational issues regarding a move-as far as the 75 Percent Rule, and that's the purpose of this call, you know, your inpatient population, whatever the numbers are, will determine if you are still considered inpatient population after you move -now when you could make that move and what type of requirements you must meet for that, that I don't know to tell you through because I don't have that particular issues. I would say to ask your Regional Office staff about that.

Barbara Franklin: OK.

Peter Diaz: Because they are going to have to know where exactly you are physically located, and to see if that new location meets certain Medicare requirements, and to see if any state requirements must be met, things of that nature.

Barbara Franklin: Right. And we're aware of that, we've had those conversations.

Peter Diaz: OK, good.

Barbara Franklin: Thank you very much.

Operator: We'll go next to Susan Wallis with Vermillion Rehabilitation Hospital.

Susan Wallis: Hi, I have a question about the new fact sheet that you all published. This year is pretty straight forward. But when we go in to the 2005 cost report period, it looks as if for certain periods of time, we're going to have to maintain to different percentage thresholds. And I understand that that looks like it's related to the four months for the FI to determine our compliance, but can you give any leeway on how that's going to be justified.

And let's just say, for the – I'm looking a cost report period 9-1-2005 beginning on the review period, 5-1-05 to 8-31-05 being 50 percent, which is the last four months of your previous.

But let's just say in the previous, you know, you might have started not taking CMS 13 there towards the end, your percentage might have been a little bit about, but overall you were in compliance. What happens in this situation?



Peter Diaz: Well when we built the system that's a rolling compliance period, really. And the question kept on coming up since what the regulation – how the regulation lead is for cost reporting periods on or after, and it always – the change occurs on 7-1.

People are asking, well, OK, you know, let's say in this situation you mentioned 9-1, this is 9-1-05, what would be the percentage that your facility would have to meet? Well from 9-1-2005 forward, in fact, from 9-1-2005 to 4-30-2006 you would have to meet 60 percent. But there is that other little period from 5-1 to 8-31-2005 that's four months, that's still really part of your last cost reporting period. And that last cost reporting period in this case started on 9-1-04. And the percentage that you were having to meet during that period of time was 50 percent.

So what we captured at first, when we did your compliance determination using the system was only the first eight months of that cost reporting period. Now, with this, we're capturing the last four months. You're supposed to meet 50 percent for the entire cost reporting period. We would have a determination of what your percentage amount was for the first eight months. This system now allows for us to know what was your percentage determination for the last four months. And yes, you would have to meet 50 percent for the last four months. If you met 45 percent only, and even if you met 60 percent or more for the following eight months, it will be determined that you fail for the entire compliance review period.

Susan Wallis: OK. So we're just going to need to be able to manipulate and juggle our data around to be multi user friendly?

Peter Diaz: Yes, well you have to be thinking of the entire cost reporting period, and the fact that starting at a certain time, in your case, apparently, on 9-1 is when your cost reporting period starts. So you're being effected by this regulation every time that 9-1 rolls around. And then 9-1-04 rolls around, you were being effected by the 50 percent rule.

When 9-1-05 rolls around, you're being effected by 60 percent that you have to meet. When 9-1-06 rolls around, you're being effected by 65 percent. So what we – the reason why we came up with the concept of the compliance review period, we wanted to try to determine what was the percentage that your facility was meeting during the entire cost reporting period.

It was impossible to do that under the old system because under the old system, let's say the RO and the FI always needs a certain amount of time to do their work. If we were using cost reporting periods, instead of compliance review periods, your compliance review period in your case, would end on 8-31-04 – I'm sorry 8-31-05, and then 9-1-06 your new cost reporting period starts. Obviously, the RO could not, in one day, or the FI could not in one day do everything that they have to do and notify you as to whether on the following day, you're still going to be considered an inpatient rehab facility. That's why that four month lag period.

Susan Wallis: Right.

Peter Diaz: What was happening before was the only way that the RO and the FI could comply with the existing regulation was they basically had to ignore that at the last part of your cost reporting period, in order to have enough time to make the determination. So the compliance review period took care of that problem.

Susan Wallis: OK.

Operator: We'll go next to Brad Berquist with Allina Hospitals and Clinics.

Brad Berquist: Yes, I'm still trying to get clarification on the threshold. And say that 51 percent of our inpatients are Medicare, so that they use this presumptive method. And say, using that method, only 49 percent met the compliance threshold, with respect to the 13 diagnosis. But say our total inpatient population would be at like 60 percent.

What's the effect that say 49 percent only met the compliance threshold, does the FI still do the random sample to see what the total inpatient population is?

Peter Diaz: Yes, in fact, one of the CR sections says exactly that. It says that if in your example under the presumptive test, your inpatient rehab facility fail to meet the compliance percentage in this case, 50 percent in your example. Then it says that the fiscal intermediary must, doesn't have an option, must then go on to the second method, which is actually reading a random sample from your entire inpatient rehab population in order to make the determination.

If in your example, using that entire inpatient population, you met 60 percent, you met more than the 50 percent, and so therefore, you met the requirements. In fact, what it says in the change request, for example, is if for some reason, the FI can generate some sort of balanced report, to make that determination all for some sort of reason, it could be various reasons, then they must also automatically go to the second method of making that determination. Does that answer your question?

Brad Berquist: Yes, it does, thank you.

Operator: We'll go next to Tommy Feuer with Lourdes Rehab.

Female: Hi, can you clarify what, if any effect, the pending GAO study has on the current compliance period? For example, my understanding is that we're still, you know, looking at the 50 percent, and we're still keeping above that threshold. So when the GAO study comes out, if that study, you know, shows that nothing is changing in the reg, then you're still going back over the whole period, there's no like carve out because of this study, correct?

Peter Diaz: That's correct, yes. That's why we want the FI's to continue doing their reviews. Just take no actions until they hear further from us, because if the GAO report comes out and it's clear to us that we don't have to change the regulations, then we have all of the data to continue with the process. You know, we will continue with the process, as if, we never put that moratorium in place. And we – and the system is not effected in any sort of way. Does that answer your question?

Female: Yes. And so then we'll know when the study comes out, we basically won't know anything until the secretary responds to it on whether or not there's any changes. Is that correct?

Peter Diaz: Right. CMS would make it – you know, would then look at the recommendations, and of course, we would talk to GAO, make sure that we are seeing those recommendations the same way. And make a determination as to whether the recommendations of the GAO in any sort of way conflict with the existing regulations.

If they don't, and if GAO agrees then we don't have to publish an interim final rule. And there might be some other things that we might do based on those recommendations, but we would, of course, list a moratorium on enforcement, and continue with business as usual.

Female: Thank you.

Robin Phillips: Gwen, hi, this is Robin Phillips, can you tell me how many questions we have in the queue, please?

Operator: It looks like we still have about 30 questions remaining in the queue.

Robin Phillips: OK. We'll continue taking questions. Thank you.

Operator: We'll go next to Denise Rohrbach with Health South.

(Maria Demore): Yes, hi. This is (Maria Demore) with Health South. I have a two part question. The one had to do with a multi trauma category and whether the fiscal intermediary will be looking at DRG's from the acute care setting. At some point, this was stated in the regulation at DRG 484, 485, 486, and 487 would be used to determine whether a patient was classified in the multi trauma category.

Peter Diaz: Yes, that was stated on the preamble of one of the regulations. One of the physicians here felt that those were the appropriate DRG's from the preceding acute care state to make a determination as to whether major multiple trauma exist in that case. However, as I stated before, we did give the FI's a certain amount of discretion to use their judgment on a particular case to see if it meets one of those medical conditions. So they can also use their own professional medical judgment and experience to make a determination if a particular case meets major multiple trauma.

(Maria Demore): So are you saying that that is optional?

Peter Diaz: Well that's one of the things they can use. That's guidance that they can use. That isn't the only guidance that they have to use because once we gave them the discretion to make that determination, they can use that guidance, and I'm sure they'll find that guidance very useful. But if there's something else that they also find would help them make that determination they could use other parameters besides just that. But we obviously encourage them to look at those particular DRG codes when making that determination but they have discretion.

(Maria Demore): OK. I'm just wondering if a patient fits in to an impairment group in the multi trauma category that is an appropriate impairment that's listed in Appendix A but perhaps was not in a DRG of those four DRG's which we don't typically get that information. We're assuming that that

patient is qualifying, and we're wondering whether in fact, they may or not have been in that particular DRG.

Peter Diaz: Right. If under the presumptive method it meets one of those particular impairment groups for major multiple trauma, you won't have any problem because the very same physician who wrote that preamble piece that you just mentioned is one of the physicians that developed the codes for Appendix A.

(Maria Demore): OK. Thank you.

Operator: We'll go next to Michael Smith with Northwest Hospital.

Michael Smith: Thank you. I'm still confused a little bit on the timing of compliance for the percentages.

And so that we are a 1-1 cost reporting period. So that if I have in 1-1 – for 1-1-07 my compliance period is going to be 9-1-05 through 8-31-06, and that I would need to achieve a 60 percent threshold during that period of time. However, if I'm at say 55 percent for the 9-1-05, through 12-31-05, which would meet regulations, but is effective for the '06 period, eight months of '06, I am at say 61 or 62 percent. Would I – and so my accum would be at about 58 to 59, would I be in compliance because of the fact that my period of time in '06 was equal to or above the required period?

Peter Diaz: Just to have one question, and just to start it off again, what is the cost reporting period that you first mentioned, the first one that starts it off?

Michael Smith: I used 1-1-07.

Peter Diaz: OK, 1-1-07.

Michael Smith: It really doesn't matter, whichever one we want to talk about. But given the – basically the compliance periods, as you said, earlier straddles two cost reporting periods. So if I'm in compliance in the current year for the eight months, does that, if I'm in compliance for that period of time, and I'm also in compliance at the lower level, for the prior four months, do I meet the regulation? Or does all of my 12 month review have to be at the upper level to meet the compliance rate?

Peter Diaz: No. It doesn't have to be at the upper level. In fact, if you have an opportunity to go to – either to the CR that I mentioned, through 3704 because it's the same table in both. Or fact sheet number two, and the specific situation that you mentioned, if you look at the cost reporting period it starts on 1-1-2007, and it gives those compliance review periods that you mentioned. You'll see that for 9-1-2006 to 12-31-2006, you have to meet 60 percent. But from 1-1-2007 to 8-31-2007 you have to meet 65 percent.

Michael Smith: OK.

Peter Diaz: In other words, the 9-1-2006 to 12-31-2006 you don't have to meet 55 percent, only 50 percent.

Michael Smith: OK. Thank you very much.

Peter Diaz: OK.

Operator: We'll go next to Lane Brown with Magee Rehabilitation Hospital.

Lane Brown: This is Lane Brown from Magee Rehab hospital in Philadelphia. Would you comment on the idea that chart review for an entire sample, may be a higher standard to meet than the

presumptive review. We are a facility where less than 50 percent of our client base is Medicare funded. So all of our review will be through chart review.

Peter Diaz: Yes, I don't know if it's a higher standard. We think it's a more accurate type of review. We think it's a more accurate type of review, because as I mentioned before, there are five reasons why we call this a presumptive test. And we believe that if you're looking at medical records, you're looking at doctor's notes, nurse's notes, various therapist notes. Other types of information. You're getting a pretty good picture of that patient.

We also believe that people who are physicians and nurses, and therapists and such are not going to risk putting information in a medical record that's a legal document, that really doesn't describe what went on, because they know that if something occurs that that case is called in to question, that maybe their license might be on the line.

So we think it's a more accurate – it's more accurate information in that. We believe that what doctors and nurses and therapists document in the medical record is most of the time, of course there's exceptions to anything, but it's most of the time reflective of what's going on with that patient, and what type of patient it is, and what they were there for, and what type of treatment they receive.

Lane Brown: Thank you.

Operator: We'll go next to David McCollum with Rehabilitation Hospital of South Jersey.

David McCollum: Hi. This is a question about new IRF status. I worked with a free standing IRF initially certified by Medicare, April 3, 2003. I had an initial cost reporting period ending December 31st, 2003, and a first full cost reporting year ended December 31st, 2004. Is this IRF considered a new IRF?



Peter Diaz: I'm thinking very carefully about the dates that you gave.

David McCollum: Yes. So we've been opened about two years.

Peter Diaz: Yes, you've been open about two years. So you were – when you first were – for your first cost reporting period, you were a newer – for that purpose, because of course, you know, we had a regulation effect before. No, I don't think under that situation you'd be considered a new IRF for your cost reporting period to start, I think you might need 12-1-04. When you first started, you got to a test, to whether you were going to meet the 75 Percent Rule.

That period of time went forward. You know, we had a regulation in place, and what have you. And if you look at 412.30, you won't meet the requirements under 412.30 to be classified as a new IRF at that time. You're only classified as a new IRF once, and that's when you first start.

David McCollum: OK. Thank you.

Operator: We'll go next to Annette Lee with University Hospital.

Annette Lee: Hi. I was wondering if somebody could give an example of what type of patients would be admitted under the arthritis category. It's not a category that we use frequently. So I was wondering if somebody could give an example of a type of patient they're using to admit under that.

Peter Diaz: I don't have a physician here in the room. So it might be some sort of rheumatoid arthritis type case or something similar. You might get an idea of the types of cases if you go to Appendix A of the CR's and if you look at the arthritis like medical conditions that are listed in that CR, and you look at the impairment groups that are listed there, and you also look at the – some of the

other codes that are listed there, would give you an idea of what - of some of the arthritis type conditions.

But, you know, it could be rheumatoid arthritis. It might be some case of osteoarthritis, it all depends. But there are a number of arthritis conditions, and I don't know what they all are. I'm sure that you have clinicians in your hospital, or podiatrists in your hospitals that can speak about that.

But are you really asking what specific medical condition that's an arthritis like condition will be used to meet either 10, 11 or 12 in the regulations or the CR's?

Annette Lee: Yes, I'm just...

Peter Diaz: OK. That's what I thought you might really be asking. What you need to do with that, once again, we gave the FI's discretion to make determinations. So what you need to do is start a dialogue with your particular fiscal intermediary. Find out what their thinking is about what they consider to be conditions that meet, you know, one of those arthritis like conditions and see what their thinking is about that. And you need to talk to your specific fiscal intermediary, they have discretion. They have the decision making power. That's where you really need to get information about that.

Annette Lee: OK. Thank you very much.

Operator: We'll go next to Jeff Fine with Elmhurst Hospital.

Jeff Fine: Hi, this is Jeff Fine calling from Elmhurst Hospital Center. I had a question regarding your statement about that the fiscal intermediary will use various software's to determine the eligibility. So currently we're shooting for a target at 50 percent. Say we were to start March first, we're

looking for a compliance of 50 percent. Considering that the UB 92, and the IRF PAI have different methodologies for coding, is there the possibility that they would also use the submitted billing from the UB 92 as a way to determine the compliance ratio?

Peter Diaz: No. Because as I stated in CR's, the presumptive methodology uses the IRF PAI data that was submitted by your facility to us. It doesn't use UB 92 data which is the claims data. So it's only using one database, and that's the IRF PAI database. So that's the only data that would be used, that's the only type of data, not the claims data.

Jeff Fine: The database that's available is – that they have access to is just on Medicare cases or on all of the cases we transmitted.

Peter Diaz: No it's on the – the only types of PAI data that you're able to transmit under the regulations are number one, you must transmit data on Medicare Part A fee-for-service patients. You are allowed the option of whether you want to transmit data for what was called the old Medicare plus C, and now it's called the Medicare advantage type patient, but you don't have to. That's the only type data that's in that database. But out of the two, the only one that you must transmit is the Medicare Part A fee-for-service type of data, that's the only data that's going to be used from the database.

The database does not have data on Medicaid patients. In fact, it should not have data on Medicaid patients, that's not allowed in the regulations. It doesn't have data on private pay patients, or any other type of patients. It only has data on Medicare patients, and the two types of Medicare patients I just mentioned just a moment ago.

Jeff Fine: So in that regard then, to sort of tie in two of the other previous questions, if we're a facility that therefore, does not qualify under the presumptive eligibility measure because we have less than 50 percent Medicare patients, then should be expected to at least provide our summary of our

IRF PAI data from the appropriate interval for the fiscal intermediary or just not provide them with any further data?

Peter Diaz: No, actually the CR does talk about what information the FI should obtain from you. But it also states in there that you have the option as an IRF to submit some additional data, if you want, for the FI to consider.

Jeff Fine: I see.

Peter Diaz: It does state that in the CR.

Jeff Fine: OK. Thank you.

Operator: We'll go next to Kim O'Leary with Oxford General Hospital. Please go ahead. And we'll go next to April Bearb with Acadia Rehab Hospital.

April Bearb: Hi, my question is referring back to the diabetic neuropathy, the gentleman talked about how it was excluded from the Appendix A, I was just questioning why would that be? Why was the exclusion made on diabetic neuropathy?

Peter Diaz: You understand, I don't have one of the physicians here that created the codes. I know that they only wanted to use certain codes and make it restrictive. This diabetic neuropathy question has come up several times. They definitely did not want to include that as part of the code list. They didn't think that was an appropriate code for that particular code list. That's the only answer I can give you at this point.

April Bearb: OK. Because I was just wondering with like slide 20 specific impairment groups were excluded, so we're not sure – we have to ask our FI what those codes would be that they're considering to include?

Peter Diaz: No, if you want to see what impairment groups were included, all you have to do is go to the final rule that we published on August 7, 2001.

April Bearb: Right. I have that.

Peter Diaz: Right. And in there there's a table of all of the impairment groups. All you have to do is a simple match between all of the impairment groups that are possible, the ones that are in Appendix A, and you can easily see that we didn't include every impairment group.

April Bearb: OK. Because I was just confused with the slide 20 where it said that specific groups were excluded for certain medical because it determined that a review of medical records more appropriate. So if in that case, when they do our review, will we want to submit medical records to show that we felt that this was – should be included?

Peter Diaz: Well what you'll be submitting, first of all is number one, whatever the FI asks you to submit as far as portions of medical records for arraignment sample of cases. And if you want to submit some other additional information besides what the FI requests, you have that option to do that. In other words, if you say – if you think, well they're asking for XY&Z but we think they should also have A&B to get a better picture of this patient, you have that option.

April Bearb: OK. Thank you very much.

Operator: We'll go next to Jody Finnerty with St. John Medical Center. Please go ahead. Ms. Finnerty your line is open?

Jody Finnerty: I don't believe you're hearing me talk, are you?

Peter Diaz: We can hear you now.

Jody Finnerty: Thank you. My question was regarding the 50 percent eligibility Medicare population.

When you're saying 50 percent of the population is Medicare, is that based on discharges, or total patient days as compared to – or Medicare patient days as compared to total patient days.

Peter Diaz: No, it's not based on days. It's based on either admissions or discharges, and that's the information that you'll see in change request 3704.

Jody Finnerty: Right. OK. Thank you.

Peter Diaz: OK.

Robin Phillips: Thank you. Gwen.

Operator: Yes.

Robin Phillips: How many questions do we have left in the queue?

Operator: We're still standing by with about 25 questions remaining?

Robin Phillips: OK. I think we're going to have maybe take this, this will be our last question, and then I'll give some follow up announcements.

Operator: OK. We'll go to Mary Kapner at Clear Lake Regional Medical Center.

Dr. (Wheeler): Hello, this is Dr. (Wheeler) I'm the Medical Director at Clear Lake Rehab. I just had a quick question on your slide on reasons for the use of the term presumptive number four. You say the codes do not indicate the time requirement for the knee or hip joint replacement was met. Are you referring to that it was done immediately before admission?

Peter Diaz: Exactly.

Dr. (Wheeler): OK. Well I just wanted to make sure I wasn't sure what you were referring to. Thank you.

Robin Phillips: OK. I'm sorry that we're not able to get to all of the participants on the line with questions. I would like to thank everyone for joining our call today. And I would also like to remind you that the PowerPoint slides can be downloaded from the UDS website which is [www.udsmr.org](http://www.udsmr.org). And we also have our evaluation form that we would very much like for you to fill out. And that can be found on [http://www.cms.hhs.gov/medlearn/cont\\_eval\\_form.asp](http://www.cms.hhs.gov/medlearn/cont_eval_form.asp).

And as Pete had mentioned earlier in the call, we are going to have a second call, and that information will be sent out shortly. The call that's scheduled right now is during a conference time for the IRF, so I'm going to be rescheduling that call very soon, and we'll send out that information. I'd like to thank Pete for participating on the call today and for all of you participating on the call. And at this time, this ends our call. Thank you.

Operator: Thank you, everyone. There will be a rebroadcast of today's call starting at 5:30 p.m. eastern today. The dial in numbers are 719-457-0820 and 888-203-1112. Please enter the pass code of 3848601 pound. That concludes today's conference. You may now disconnect.

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