

**CMS**  
**Moderator: Robin Phillips**  
**March 23, 2005**  
**1:00 p.m. CT**

Operator: Good day everyone, and welcome to this Inpatient Rehabilitation Facility Provider Training conference call, 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.

I will now turn the conference over Robin Phillips. You may begin.

Robin Phillips: Thank you. Hi. This is Robin Phillips. I'm with the Provider Communications Group, Division of Provider Information Planning and Development at CMS in Baltimore. I'd like to welcome everyone today to our IRF Provider Education conference call.

We're going to begin our call today with a presentation from Pete Diaz from the Division of Institutional Post Acute Care, and following that will be a question and answer session.

An encore of the call will be available two hours following the call today and will be available for five days. To access that encore feature, you can dial 719-457-0820 or 888-203-1112. The pass code is 4225450.

Medicare contractors, Central Office, and Regional Office staff have been invited to listen to our call today, and as the operator said, the call is being recorded and transcribed, so please identify yourself before we speak. At this – before you speak. I'm sorry.

At this time I would like to have each person here in CMS in the Baltimore office introduce yourself and say what component you're with.

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

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

Georgia Thompson: Georgia Thompson, Division of Continuing Care Provider.

Robin Phillips: Thank you. At this time, I would like to turn the call over to Pete.

Pete Diaz: Thank you, Robin. This is the second of two calls that we planned to do with the provider community. We've also already have had a couple of calls within the last couple of months with all the Regional Offices and all the FIs, and we also had some calls with the Regional Offices and the FIs back last summer.

I hope that everybody had a chance to download the slides from our website. I'm going to be talking directly from those slides. Some of the times I'll just be reading directly from the slides, and other times I'll just be referring to them. Either way I, of course, include some additional information that's not on the slides.

OK. The first slide – and I'm going to try to go rather quickly. I want to try to only use up about 40, 45 minutes total for my speaking time in order to allow the most time possible for questions and answers.

OK. The first slide just has my name and the fact that I'm a team leader for the Inpatient Rehab Facility Prospective Payment System.

Slide number two has the three topics that are going to be discussed during this conference call. Number one is the 75 percent rule, which officially is 42 Code of Federal Regulations 412.23 – disregard the 9– it's 412.23(b)(2).

And excuse me. The next one is what's considered a new IRF unit versus a converted unit, 42 CFR 412.30 is the official regulation site, and it's – the reason I'm going to be talking a little bit about this is, whether you're considered a new IRF unit or converted IRF unit, definitely has implications regarding the 75 percent rule.

And the last one I'm going to be talking about is changes in the status of a hospital or hospital unit, which is 42 CFR 412.23(i) and 42 CFR (412.25(c) and (f) C like in Charlie and F like in foxtrot.

Slide number three is entitled "General Legal Background." I'm not going to read everything on this slide and slide number three and four because I would have to be mentioning, of course, a lot of the sections from the Social Security Act, and you should have the slides right there in front of you, and you've got it right there.

The importance of this is, actually, we mentioned this very same type of legal justification for the 75 percent rule, and this comes from our Federal Register of Publications. So, if you want to find

out a little bit more about this, you can look at the publications that we issued that talked about the 75 percent rule and, of course, you can go to the Social Security Act itself and look these sections up.

Section 1820 of the Social Security Act, the one having – the one that deals with the establishment of critical access hospitals, is the one exception. That's – I actually got that reference from a survey and certification letter that is up on the CMS website. It's not on the IRF PPS website but it's – you can find it by going to the CMS website. And it talks about a critical access hospital. A critical access hospital is limited to having no more than 25 beds and is not paid under the inpatient, which is the acute care hospital, which is normally called a DRG system, payment system, prospective payment system.

Before October 1, 2004, a critical access hospital was not allowed to have what's called a distinct part unit. Distinct part units are not only rehab units, but also psychiatric units. After October 1, 2004, they could have one of each, and each one could be no more than 10 beds. I'll, of course, just be addressing what the inpatient rehab facility has to meet. And in a nutshell, what they have to meet is just like any other inpatient rehab facility under the IRF PPS system.

I'm on slide four right now, and the important thing to note from slide four is the part in the middle where it says the DPU – in other words, the critical access hospital DPU may be a rehabilitation unit DPU, and the DPU beds are not included when determining the number of beds in the CAH. So if a CAH – critical access hospital – is up to their limit of 25 beds, they can still have an additional 10 beds, for example, that's an IRF unit, and it's not counted against their 25-bed limit.

There are implications as to what happens if that IRF unit no longer qualifies as an IRF. And the implications would be if the CAH already has a 25-bed unit and the IRF no longer qualifies as an IRF, those 10 beds cannot be folded back into the CAH because they're already at their 25-bed limit.

But let's say, for example, the CAH only had 15 beds and they still had an IRF unit that had 10 beds, and that IRF unit no longer met the criteria to be classified as an IRF, if those 10 beds met all the other criteria to be classified under the CAH, those 10 beds could be folded into the CAH, and the CAH would just rise up to its 25 bed limit. But you notice I said, if those 10 beds also met all of the other requirements to be classified as critical access hospital type beds.

And that's something that, if you have questions about, please address with your survey and certification staff at the Regional Office.

A critical access rehabilitation unit is paid under the IRF PPS if it meets all the requirements to be paid under the IRF PPS. I'm on slide number five, IRF classification requirements. In order to be classified as an IRF, the facility must meet the requirements to be classified as an acute care hospital, acute care unit, or as a critical access hospital.

And the important thing to take from that point is the 75 percent rule is only one of the requirements that a facility must meet to be considered an inpatient rehab facility. These other requirements are stated in the regulations. You could find them at 412.23, 412.25, 412.29, and 412.30. You can also find the very same requirements reiterated in the CR's that we have issued over the last few months.

Point number two on slide number five, after the facility meets the requirements to be classified as an acute care hospital, acute care unit, or CAH, it must meet the other additional requirements to be classified as an IRF. Most of the other requirements are actually verified by state agencies – not all of them, but most of them are. I have been asked several times whether the FI is responsible for verifying these other specific requirements and, in general, the answer is no. There are some requirements that are listed in 412.25, as I recall, that talk about basically

accounting-type standards, and yes, those are FI type standards that they would – that they would have to verify.

But most of the other requirements are either verified by the state agency, or there's actually several of them that the providers themselves can actually self-attest to. But I want to make the point right from the very beginning, because this is what caused the problem, that the 75 percent rule in no case can be – no, I should not say in no case. The 75 percent rule, with one exception – and I'll mention that in a moment – cannot be self-attested to. The one exception is, if the facility is indeed classified as a new facility under 412.30 or some other variations in there as far as whether it's new beds or a new unit, then in that case the facility can self-attest that it's going to meet the 75 percent rule in the coming year, and the FI would then verify later on if that was indeed the case. So, that's the only exception.

That's the big difference between being classified as a new IRF or being classified as a converted IRF.

OK. Point number three, 42 CFR 412.23(b)(2) is only one of the requirements in order to be classified as an IRF, and I've just spoken about that.

Slide number six, "What is the compliance percentage threshold?" There have been several questions asked about this, and I figured it would be best to just put it on a slide so that people could have something to read about this.

So, it's the percentage of an IRF's total inpatient population that must match one or more of the 13 conditions specified in the regulations. That's what that term means, the compliance percentage threshold. And the compliance percentage threshold that we're in right now, because right now it's after July 1, 2004, and before July 1, 2005, we're in that time period right now, so the compliance percentage threshold right now is 50 percent. And for cost reporting periods

starting on or after July 1, 2005 and before July 1, 2006, 60 percent; and for cost reporting periods beginning on or after July 1, 2006 and before July 1, 2007, 65 percent. And on slide seven, for cost reporting periods beginning on or after July 1, 2007, the compliance threshold is 75 percent.

The important point you should take away from this is that phrase, "For cost reporting periods beginning on or after." Let me give you an example. Let's say your cost reporting period starts on October 1, 2005. I could have chosen January 1, 2005. Doesn't matter. So, let's say your cost reporting period starts on July – on October 1, 2005. I just said that the compliance percentage threshold becomes 60 percent for cost reporting periods starting on or after July 1, 2005. That means that your facility, with a cost reporting period that starts on October 1, 2005 would not have to meet that 60 percent compliance threshold until October 1, 2005.

Slide number eight, "Which are the medical conditions used to determine compliance with the 75 percent rule?" I'm not going to read the information on slides eight, nine, 10 or 11. I think people either have the information right there in front of them on the slides or they have seen this information in the regulations already several times.

However, I am going to make reference to one of the parameters that's talked about for conditions 10, 11 and 12, which is the arthritis-like conditions, and that's the therapy parameter for those conditions – how much therapy the patient must receive prior to that condition really being considered to have been met. Please take note of that. I'm going to be referring to that a little bit further on in this presentation when I talk about the presumptive method of verification and the reading of medical records method of verification.

There's also, on slide number 12, where it talks about knee and hip joint replacement. That medical condition, you notice that there's also a time parameter, and there the time parameter being that it says "knee or hip joint replacement or both during an acute hospitalization

immediately preceding the inpatient rehab stay.” And I wanted to mention that because I’ll also be referring to that in a few minutes.

I’m on slide number 13, which is entitled, “Which are the medical conditions used to determine compliance with 42 CFR 412.23(b)(2),” and the important point to be taken from here is we wanted – in case this improved compliance in any sort of way, we wanted to not only have a patient’s primary principle diagnosis for admission to an inpatient rehab facility – in other words, why the patient is there, why they’re there to receive rehab – to be the medical condition that matched one of those 13 conditions, but in case there was a time that, for some reason, the patient was admitted under some other sort of principle diagnosis but had a comorbidity that they were actually in there and also receiving rehab for, that we could use that – the IRF could use that to match one of the 13 conditions and hopefully help them to meet the compliance percentage threshold.

So, that’s what’s really being said in this slide. But you notice that we did attach some parameters. We said the comorbidity matches one of the conditions specified in the regulations, and the comorbidity itself caused significant decline in functional ability in the individual such that even, in the absence of the admitting condition, the individual would require the intensive rehab treatment that is unique to inpatient rehab facilities paid for under the IRF PPS.

Now somebody, for example, could have a comorbidity that matched one of the 13 conditions, but we didn’t – was not causing significant functional decline at that time, and the patient was really not there in the IRF to be rehabbed for that, in a technical sense, and especially if a FI is reading the medical records to determine compliance, they should be able to see that, and in that case, that comorbidity would not match one of the 13 conditions.



However, when I talk about the presumptive method, you'll see that, if your compliance is based only on the presumptive method, we don't have the ability to capture that information, and you may qualify even if that particular parameter was not met.

OK. Slide number 14, "Reasons for the use of the term presumptive." People have asked, what does that mean? Why did you put that term in there? And I've thought of at least five reasons why we put that term in there. I would imagine somebody else could probably come up with one or two more.

But first of all, the determination methodology under the presumptive method – and the presumptive method is a method that I'll be talking about just a little bit more – but the presumptive method is basically a software-driven method. Some of you who have already read the slides are familiar with that already, but it's a software-driven method. And, you know, when you use software, when you use a computer program, there is only a certain amount of information that you can capture using codes.

So, the determination methodology is applied, first of all, only to the Medicare Part A fee-for-service portion of the IRF's total patient population, not the IRF's total inpatient population. That's reason number one why we say presumptive. And what we're really trying to say here is this – if you look at the regulation, the regulation actually says that we're supposed to determine compliance based on the total inpatient population, not just the Medicare Part A fee-for-service portion of the population.

However, a couple of years ago the Rand Corporation, one of our data analyst contractors looked at this issue very closely, and they found a very high correlation, almost a one-to-one, but not quite, a very close one-to-one between the meeting compliance based on the Medicare Part A fee-for-service part of the population and the total inpatient population.

So, we thought, well, OK, if we're going to do this by a software-driven method, we'll go ahead and live with that slight uncertainty, especially since it actually works in the favor of the inpatient rehab facilities if you meet compliance this way, since if you don't meet compliance this way, you still have another bite at the apple, you still have a chance to meet compliance by – by having your medical records read. So, this works in your advantage.

Slide number 15. Reason number two. In general, initially CMS does not know if the codes recorded in the IRF PAI reflect the patient's actual medical condition. Either due to a clerical or just deliberately putting false information in the IRF PAI, the codes that are on there we have no way, if the IRF committed a deliberate act or if it was clerical error, we have no way of knowing if those codes actually reflect what the patient's actual medical condition is unless we actually do look in further, in other words, by medical review or some other type of looking at the patient's medical record.

So, we are taking it on faith that the vast majority of the industry, we think, is basically going to give us accurate information, but we have no way of actually knowing that initially.

Reason number three, the codes don't indicate if the therapy requirement, that I just talked about a little while ago, if the therapy requirement for the arthritis-like conditions, conditions 10, 11 and 12 was met. The codes can't capture that type of information.

Reason number four, the codes do not indicate if the time requirement for the knee or hip joint replacement condition was met, the time requirement that I just talked about a minute ago.

And condition number five – reason number five, the comorbidity codes do not indicate if the comorbidity being included in the compliance percentage determination meets the requirement specified previously.

So, we were willing to live with that type of uncertainty as far as the presumptive method of compliance, and we recognized that when we put the system into effect.

Slide number 16, about how compliance will be met by the fiscal intermediary using software that will allow fiscal intermediary to make a presumptive determination regarding if a facility met the compliance percentage threshold, and number two, which is the gold standard, by the fiscal intermediary reading a random sample of selected portions of individual medical records to determine if the compliance percentage threshold was met.

How is the presumptive method performed? The fiscal intermediary first determines if at least 50 percent of the facility's total inpatient population is composed of Medicare Part A fee-for-service patients. If this standard is not met, then the presumptive method cannot be used to determine if a facility met the compliance percentage. There have been some questions that were raised about this, about what this meant. I think it's fairly clear, but if you have questions during the Q&A time about this, feel free to ask.

We're using only the Medicare Part A fee-for-service part of the population to determine if 50 percent of the facility's total inpatient population is composed of Medicare Part A, because there is another type of Medicare as people know before that used to be called Medicare Part C, now it's called Medicare Advantage, and a facility is not required to, but may – not required to, but may send PAI data to our contractor on those patients. But since they're not required to, we only wanted to use the records that – from the IRF that the IRF was actually required to send, and those are the Medicare Part A fee-for-service patients.

So this standard must first be met before the presumptive method can be used to determine if a facility met the compliance percentage threshold.

The presumptive methodology uses a computer program that produces an electronic report from the IRF PAI records and the IRF PAI database.

Slide number 18, the fiscal intermediary will access the QIES website and, using that website, the fiscal intermediary will generate the report. This is a restricted website. You can get to it, but you won't be able to log in unless you have a password. We control tightly how that password is issued, so it's only people that -- selected personnel of the FI and some CMS staff that can actually get into that website. If you go to the website, though, itself, though, you can at least see that that website is used not only for -- by -- for IRF purposes, but it's also used for the NBS and the OASIS and some other purposes.

But that's the website that the FIs will go to in order to use some software that's centrally controlled to actually get the report that they would use under the presumptive method. There's really not much that they have to do. The instructions about how to do it have been issued. I've issued some separate instructions to the FIs about when they get to the website, step by step about what they need to do in order to generate the report. There's also a help desk number in there that the FIs or the ROs can use to call the contractor if they're having any problems.

In addition to that, I also issued to the FIs and the ROs an instruction -- a set of instructions labeled "How to Interpret and Use the QIES IRF 75 Percent Rule Report." I'm going to have this document that I just mentioned, "How to Interpret and Use the QIES IRF 75 Percent Rule Report," put up on the IRF PPS website. The first document I mentioned about accessing, and that's only on the FI RO contractor website. But this other one is just how to interpret and use because -- one of the CRs that we issued recently -- CR 3704, which was issued on February 18, 2005, contains a generic rehab eligibility report. And I thought that there was a need for some additional information to be issued as to how to actually read that report, and this other piece of information that we'll put up on our website will tell you step by step how to interpret any one of

those boxes in the report, what they mean, and how they're going to be used by the FI to determine your compliance percentage.

As is mentioned over here, the report will have two columns, each showing a percentage of the IRF's Medicare Part A fee-for-service inpatient population that matches at least one of the medical conditions specified in the regulations, and the codes that are in the centralized software come from the CRs, and it comes from the Appendix A of the CRs that we have issued, the Change Request that we have issued that are also called Program Transmittals. One of them was Program Transmittal 347, the other one is Program Transmittal 221, and the latest one was Program Transmittal 478.

So, the impairment group codes, etiologic diagnosis codes, and comorbidity codes specified in Appendix A of the Program Transmittals were used to develop the computer program. In general, if an IRF PAI data record has an impairment group code or an etiologic diagnosis code or comorbidity code that matches one of the codes specified in Appendix A, that patient is presumptively counted as meeting the compliance percentage.

Notice that I really emphasize the word or because one of the questions that I've been asked frequently was, did the patient have to match all three of these types of codes? No, only one of the types of codes, and that is – that is stated very specifically in the CR that we issued, Transmittal 347, Change Request 3503.

How is the presumptive method performed? Specific impairment group codes, the software is going to be looking for specific impairment group or comorbidity, etiologic diagnosis codes from Appendix A. And what we did here was, we had our physicians make a determination as to what would be the subset of the total possible universal codes that could be in the IRF PAI data records that the IRF facility submitted. That subset should determine whether a case met one of the 13 conditions. And we did that in a very restrictive way. This was going to be done by

computer software. As far as the FI, it doesn't have to be a medical professional running the software. It could be a clerk or anybody else because it's just a computer method and that's about it.

So, we want it to be very restrictive, and we felt we were justified because, if an IRF doesn't meet the compliance percentage based on the software's method, that doesn't mean that the IRF has failed. That means that the FI must go to method number two and use a random sample to actually determine if the IRF doesn't meet the compliance percentage or not.

Slide number 21 talks a little bit more about how the compliance percentage would be met. I've talked about this already.

Slide number 22 – the important thing to note from slide number 22 is that the FI always has discretion to include a patient and any of the medical conditions listed on the regulation based upon the review of the clinical record, regardless of the presumptive test methodology described above.

That goes two ways. Number one is, let's say an IRF did meet the compliance percentage based on the presumptive methodology, that doesn't mean that the FI has to stop there. The FI has discretion to actually go to method number two and make the determination that way. Does the FI have to do that? No. Can the FI do that if they want to? Yes. They might have some other reasons for kind of questioning whether this IRF really met the compliance percentage threshold. They might have some other information indicating that maybe they should look further. They don't have to, but they may.

What that means is when they – when they go to method number two, they really have a lot of discretion. Number one is they can just use the very same codes from Appendix A. They can use the codes from Appendix A with some other set codes that they think are appropriate. They

can just use – they can disregard the code list in Appendix A and just use – just have their medical personnel, in other words, an RN, a physician, an OT, or a PT, or somebody else with equivalent experience and training reading selected portions of medical records and making a determination that way. They have lot – they have a lot of discretion in that way.

The only thing that the FI has to do if they're going to use some other sorts of methods is they're going to have some standardized way of doing it so that, if a facility fails, they can't claim that I failed and facility X didn't fail because you did your – you did it this way for them and you did it that way for us, and it was unfair. But other than that, they have discretion – they have a lot of discretion.

“What is the compliance review period?” This is slide number 23. In the time period from which data will be selected to make the compliance percentage, in general, that time period is 12 months. However, in certain situations, as specified in the Program Transmittals and Change Requests, and also in the regulation that we published back on May 7, 2004, that time period can be different.

The relationship of a cost reporting period to the compliance review period, the cost reporting period establishes the compliance percentage that must be met. In other words, the example I presented before, let's say your cost reporting period starts on October 1, 2005. The percentage that must be met from that time forward is 60 percent. The compliance review period establishes which time period will be used to select data that will determine if the compliance percentage was met for a specific cost reporting period.

So, let's go back to that example, October 1, 2005. From October 1, 2005, forward eight months, you're going – that IRF would have to meet 60 percent. For the four months prior – in other words, September, August, July and June – for those four months prior they would only have to

meet 50 percent because the cost reporting period that – the prior cost reporting period, which in this case would have been October 1, 2004, said that they only had to meet 50 percent.

We have published on our website a couple of facts sheets. Fact sheet number two has a long table that's also included in the same table from CR 3704, and it shows this in a table-type manner so that – with dates associated with it.

Slide number 25, the inpatient rehab facility provider eligibility report. This is the same generic report that's in CR 3704, which is Program Transmittal 478. It's also the same generic example that you'll see when we post the instructions on our website that's labeled "How to Interpret and Use the QIES IRF 75 Percent Rule Report."

So, refer to those instructions as far as getting a better idea how this report will be interpreted. There is some language, some text about this in the – in Program Transmittal 478, but unless you really read it very, very carefully, and probably more than once, you'll miss some of the concepts, how they're interrelated. That's why, I issued just a simple one, two, three type of instruction sheet that ties all those concepts together.

Slide number 26, "Failure to Meet IRF Classification Requirements." If you're – in general, under 412.23(i) and 412.25(c) and (f), a change to the classification status of an excluded hospital – excluded from what? Excluded from the inpatient prospective payment system – in other words, the DRG system. So, change in – to the classification of an excluded hospital unit is made only at the beginning of a cost reporting period.

Sometimes, unfortunately, some facilities have failed to take that into account. They have a lot of plans in place, either building something or making some other sort of changes, and they're planning to change their classification at a certain period of time. They don't realize that it's going to have to be done at the beginning of the cost reporting period. The way that they're going about



things, it's not going to be when the next cost reporting period starts. That means they're going to have to wait again, another year in most cases, until the cost reporting period starts again. So, you might want to look at those two regulations.

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

Slide number 27, "The Effect of the Consolidated Appropriations Act, 2005, on the Revised Classification Requirements for IRFs." A number of you are probably aware that there was a law passed and it did affect what CMS would be able to do in the future, and these slides basically address that.

So, you have to look at these slides very carefully because you notice there's a date there, June 30, 2004. It's a critical date. CMS may not change the classification of the facilities that were classified as IRFs as of June 30, 2004 until CMS either determines that our current regulations – in other words, the 75 percent rule- are not inconsistent with a soon-to-be released Government Accountability Office IRF study, and that final study still has not been released; or two, in accordance with the provisions of the same soon-to-be released GAO IRF study, issues an interim final rule, and I say in here regarding the criteria, but actually we looked up the law a little bit further, and it doesn't say specifically why its in the criteria, but the inference would be that we would have to make some sort of change.

FIs will continue to perform the compliance reviews on all IRFs. This is being done right now. So, although we issued a joint signature memorandum due to the effect of the Consolidated

Appropriations Act saying hey, you know, for these IRFs, don't change their classification until further notice from CMS headquarters here in Baltimore.

We told the Regional Offices and the FIs, continue doing all the reviews because if the GAO study, when it's released, doesn't mean we have to change anything, all we have to do is issue another joint signature memorandum, that's an internal document, saying OK, if we continue now to full enforcement, the reviews will continue to be done. We have all the data. Things were just like we never imposed a moratorium on enforcement in the first place.

And I state this because somebody did send an e-mail about a week or two ago stating that there was an IRF not wanting to comply with some of the instructions from the FI, and was wondering if the requirement there about, if they didn't comply with the instructions from the FI and from the Regional Office, what the requirement stated in CR that a default judgment would made, but the IRF would just automatically lose its classification if we were to enforce that.

And my answer was no, because doing that would be just like if the enforcement was done based on a regular review. However, I did caution that the person who sent them the e-mail to let others know that we are continuing the reviews and all – we're gathering everything up just like before. So, if we issue another joint signature memorandum and we say, OK, enforcement is on, and that IRF had not complied with the instructions, we have that information, and their cost reporting period hasn't started yet, guess what? We will issue a default judgment saying, you no longer qualify as an IRF.

So if a facility wants to take that risk – I wouldn't want to be taking that risk – but if you want to take that risk, that's what could easily happen.

As you know, basically that – you know, the next time that – the first time that anybody would really be effected would be for cost reporting periods that start on July 1, 2005 or afterwards, we

think that, a long time before that, the GAO is going to issue their final report, and if it's such that we don't have to change anything, we're of course going to immediately lift the – our plan is to lift immediately the moratorium on enforcement unless, at a higher level, we're told to keep it in place for some other sort of reason. But that is our plan.

So, I'm on slide number 29. The important point to take from slide number 29 is what we're saying is the moratorium on enforcement only applies to the 75 percent rule. I mentioned before that there are other requirements that an inpatient rehab facility must meet, and if they don't meet any of these other requirements, regardless as to whether they were classified as an IRF on or before June 30, 2004 – if they don't meet those other requirements, we can still change their classification.

The other thing is, look at the date June 30, 2004. If you're an IRF that wasn't classified on that date – let's say you were classified for the first time as an IRF on August 1, 2004 – that – the law didn't apply to that particular facility, and that joint signature memorandum specifying a moratorium enforcement doesn't apply to that facility either.

Slide number 31, "New IRF Unit Versus Converted Unit" – 42 CFR 412.30 is the regulation – 31 and 32 look very similar.

I'm sorry, 32 and 33 look very similar. Slide 32 and 33, but there's a – there's a slight difference 33 to 34. I'm sorry for keeping on using different slide numbers, but it's slide 33 and 34.

If an IRF is a new IRF according to 412.30, it can self-attest that it met the requirement – the 75 percent rule requirement, and the FI will later determine if that's the case. If the IRF is undergoing the conversion process to become an IRF, it must actually meet the 75 percent rule during the conversion time before it can be considered an IRF.

Now we are finally to 33 and 34 – excuse me once again for mentioning before because these are the two slides that look very similar to each other, but when you look at it, what we're seeing in slide 33 is this – the change in classification of a unit from non-excluded from the acute care hospital inpatient prospective payment system to excluded may be made only at the start of a cost reporting period. So, when you're going from non-excluded – not excluded from the DRG payment system and you want to be excluded – in other words, you want to become an IRF – that can only be done at the start of a cost reporting period.

If you want to go the other way – this is slide 34 – if you want to go from being excluded to already an IRF and for some reason you want to be paid instead under the inpatient prospective payment system – so you want to go from excluded to non-excluded, that change may be made at any time during a cost reporting period if CMS Regional Office and the facility's FI are notified in accordance with the notification requirements in the regulation, because they of course have to process some things--things like provider number change and things of that nature. So, they need some time to be able to do that.

That ends my part of the presentation. In a few minutes I'm hoping that Dr. James Bowman will join us. There was a request made that we have a physician present during the next provider call that we had. I did ask Dr. Bowman to join us, and he said he would be here. So, if he's not here at this point, when he walks in, I'll go ahead and mention that, so if anybody wants to ask him a specific question, he'll be available.

Thank you.

Robin Phillips: Thank you, Pete. Before we begin the question and answer session, I would like to have everyone's feedback today on our call. So, if you would have an opportunity – if you would take an opportunity, please, to complete and send it quickly a training evaluation form that can be found on our evaluation website here. It's [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. Appreciate everyone sending their comments before.

At this time, we can open the call for questions and answers, but I would like to remind you that this call is being recorded and transcribed, so please give us your name and the name of your company. In an effort to get as many questions as possible, we ask that you limit your questions to one and we hope we have enough time to answer everyone's questions today.

Operator, we're ready to open the call for questions.

Operator: Thank you. Again, ladies and gentlemen, to ask your questions, please press star one at this time. Again for your questions or comments, please press star one.

We'll go first to James Blanton, East Texas Medical Center.

James Blanton: Yes. This is James Blanton with East Texas Medical Center. I've got a question as it relates to comorbidity. Specifically we ran across a case here recently that had a comorbidity V 4975 ICD-9 code, which is a below the knee amputation, and he fractured his other leg – it's an older amputation, OK. And he fractured his other leg.

And when I read the – when I read the stuff here that's on – in your handout that says the comorbidity matches one of the conditions specified above dah-di-dah-di-dah, I have a hard time ever finding where I can ever have a qualifying comorbidity that meets that, really. That's – would you consider the example I just told you a qualifying comorbidity?

Pete Diaz: It could be. It's – as I recall, we don't have that code on the Appendix A code list, but that doesn't mean that, when the – that when the FI is reading selected sections of the medical record and they're making determination that way as to why the patient was in the rehab facility in the

first place – why the patient was being rehabbed, if it had a significant functional decline – if that information is based either on the code or just what they're reading from the admit notes, the discharge notes, the OT notes, PT notes and things of that nature – then the determination is made that way.

In other words, they don't have to use the code. They can just ...

James Blanton: Right, right.

Pete Diaz: ... they're trying to get a picture of the patient and why they're there.

James Blanton: OK. Well, you know – where I have problems with this is where it says, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to IRFs – if that's the case, I mean, if I'm – you know, basically I have amputation then, don't I, and that's a qualifier anyway.

I mean, I just don't see how I can ever make that – it's seems like it's kind of double-speak there on that as it relates to, like, this case and some others that I've thought of as well.

Pete Diaz: Yes, we've put that in--in case when we were writing this there might be – there might be a situation where a patient was being admitted and maybe the code for the rehabilitation impairment group or one of the comorbidity codes, or one of the etiologic diagnoses codes would be such that it wouldn't match one of the 13 – one of the 13 conditions.

But maybe the patient – I'm sorry – had a comorbidity code that did match in case there was that kind of a problem. Sometimes a problem like that might occur due to miscoding or something, or maybe some sort of slight error that might be – there might be some other reason that we weren't – we couldn't quite envision at that time, but we wanted to give the possibility if that occurred, that

that would actually, you know, result in a match. It doesn't work against you. It actually, if something like that occurs, it works for you.

James Blanton: Oh, absolutely, absolutely. It's just a little quirky there. We're trying to do it right, so – alright, thank you ...

Pete Diaz: ... we can't – we can't when we're writing these things--we tried to – you know, we have groups of people that meet and think about all kinds of different things. But when you're things for the first time, things that are brand new, we can't capture every possibility and when possible when we're writing some regulations or some instructions, we do try to get some ways that maybe things could be done on an exception basis in some sort of manner, and that was what we tried to do there, you know, to see if that was possible.

James Blanton: OK. All right. Well, I appreciate it. Thank you.

Robin Phillips: Thank you, James. Next question, please.

Operator: We'll go now to Joy Harde, University Health Systems of Eastern Carolina.

Joy Harde: Hi. Good afternoon. Had a question about the 13 conditions that are listed. Is there a specific ICD-9 code listing somewhere for those 13 conditions, because take number five for example, major multiple trauma. That could be a zillion different codes, quite frankly. Same thing for burns, same thing for amputation. Is it just above and below the knee amputation, or is it amputation of the upper extremities, or amputation of the toes?

Pete Diaz: No, the only code that you would find if for any of these conditions as far as the ones that the physicians here consider would match one of the medical conditions are the ones in Appendix A. After that, if there isn't a code in that way, it's going to be left to the medical staff at the FI level to

either – if they want to--these codes or just to use a reading of the medical records sections to make a determination.

But, no, we didn't come up with, let's say, major multiple trauma are all these codes and therefore, FI – if the patient matches any one of these codes, they're definitely in, no that we didn't want to do, and we didn't want to do that because, if we did that, that would indeed take away the discretion that the FI could use.

If you want to go with a hard list, you got one thing. You might get some additional assistance, I'll tell you what you lose right away, you lose the ability of, at the local level, making your case to your fiscal intermediary staff and having that case make a match. So, it works both ways.

Let me say one thing before I continue, though, just so that people will know. I said I would say this when he came in. Dr. James Bowman just joined us, so, for those of you later on that want to have some questions directed to somebody who's a physician, there is one available.

Joy Harde: When you reference Appendix A, is that in the regulation itself or where can I...

Pete Diaz: No. Appendix A is the appendix that you'll find, first of all, we had it in the first Change Request 3334, which is Program Transmittal 221, and then we had it – we made some corrections to it, some technical corrections due to the fact that some of the fourth- and fifth-digit codes, for example, were incorrect. In other words, if the code is – I don't know, I'm just taking this out of the air – let's say it's 734.01 and it really should have been 734.05 or something like that. So, it had some problem in the fifth digit. You know, we made those types of corrections.

But – and then we did add a few more codes to the actual list to – due to some comments that had come in – not many, but we did add a few in order to – in order to say this code would also meet one of those conditions. But it's Appendix A, and you'll find it –in that, you can find it in



Transmittal 347, which is Change Request 3503, or you can see it – or you can also see the list and Change Request 3704, which is Transmittal 478.

Joy Harde: Thank you.

Operator: We'll take our next question from Lyndel Mead at Sid Peterson Memorial Hospital.

Lyndel Mead: Hello?

Pete Diaz: Hello.

Lyndel Mead: On the documentation required to meet the severe advanced osteoarthritic conditions, for the therapy documentation do we need to include outpatient – you know, the failed outpatient therapy notes?

Pete Diaz: So, when you're documenting what went on with this patient ...

Lyndel Mead: Prior to admitting to an IRF for one of the severe osteoarthritic conditions ...

Pete Diaz: Right. What is – the – what is – what's talked about in the regulations, you know, what's in the CR's exactly word for word as far as the medical condition as to what's in the regulation ...

Lyndel Mead: Yes.

Pete Diaz: ... talks about rehabilitation in another, less intensive rehabilitation setting, and that includes outpatient, OK? So, if they had that, yes, you would want to document that. You'd want to be showing that the rehabilitation consisted of at least three weeks' minimum duration with at least two individual non-group therapy sessions per week targeting all clinically impaired joints,

supported by documentation or medical record of office services, with periodic assessments for clinical functional improvement, within 20 calendar days of an acute hospitalization preceding immediately an IRF stay and, you know, and it just goes on and on like that.

So, you know, that's what you would want to – that's what you would want to show.

Lyndel Mead: OK. So, if you – if the FI asked for a review of that medical record, then you're going to want to have access to those outpatient notes to send with the record, right?

Pete Diaz: Yes. You would – if that would be something that you would want to show if possible, or at least if you didn't have – let's say, for some reason, you couldn't get a hold of the outpatient notes, that you could at least make – you know, prove that that was the case in some other way.

In other words, you're going to – you would have to show in writing that the patient actually met that. I guess maybe you could work with the FI, and maybe if they had some sort of method of having you attest to it in some sort of way so that you attest to it in a legal way and what have you, I guess that would be one way.

I'm looking at – I'm looking right now at Bob, who is my division director, and see if there is anything that he wants to add about that – about how that could be done, because I think we're you're saying is we couldn't get a hold of the records from the outpatient facility for that entire period of time and is there some other way that we could prove that?

Lyndel Mead: Yes. Yes.

Bob Kuhl: I'm not sure – I'm not sure if there is other than staying in touch with the fiscal intermediary that would be performing the review to make a determination if maybe those kind of records can be received by the intermediaries themselves. I'm not sure.

Pete Diaz: Yes, we haven't put out anything more about that requirement. I could see one or two different ways. Right now we haven't put anything out. We can work with the FIs to see what might be – what might work best for them before we put out some more specific instructions about that, because we wouldn't want to put something out here from central office on a national level that maybe, in some parts of the nation, could not be met for some very good reason.

Lyndel Mead: OK.

Pete Diaz: ... first consulting with the FIs.

Lyndel Mead: All right. Thank you.

Robin Phillips: May I get your name, please?

Operator: I'm sorry, caller. Please press star one again.

Pete Diaz: ... if you want to mention it. Dr. Bowman here – he's sitting to my left – he did mention one other thing that might be something he might do, and I emphasize might because, you know, we haven't actually issued any instructions about this. But it's something we could think about go ahead, Dr. Bowman.

Female: ... it's philosophy is caring for all ...

Dr. James Bowman: Sometimes the outpatient physical therapist or the rehab medical director of the outpatient clinic might provide a summary report detailing the summary overview of the course of rehab therapy that that patient has had over the last three to four or five, six weeks as a – even in the form of a detailed letter or a follow-up summary report to the attending physician as a way of

maybe documenting, with less intensity, of all the numerous pages of progress notes that otherwise would have to be provided, but could still detail the number of visits, how often, how frequent, lack of progress, or minimal progress or whatever.

Operator: And Mr. Mead, your line is reopened.

Lyndel Mead: Thank you. That's all I have.

Robin Phillips: Thank you.

Pete Diaz: Once again, we haven't put down anything in writing about this –these are methods that right now, you could use, being that we've been silent about this, before we actually put something out in writing, I'd want us to check with a few FIs and look at the pros and cons of the instructions that we would put out.

Operator: We'll take our next question from Maria Guerrero with Denton Regional Medical Center.

Maria Guerrero: Good afternoon. We have a question regarding medical necessity. If you could define that for us, it would help us greatly.

Pete Diaz: That's not something that I can define. That's something that's in the purview of physicians, that's for sure. And I can tell you this, as far as how CMS operates, and that's not a definition that's going to be coming out of this division.

You know, it's just like any other organization. We're divided into various components and that's really not the purview of this division of the Office of Financial Management. Program Integrity Group is the section that oversees the fiscal intermediaries, and particularly for their medical review type functions. We work with them, of course. I mean, they don't work in isolation.

But that's something that I would defer to them if they wanted to issue a definition of medical necessity. Also, that's not something that we would issue by way of some sort of CR or anything like that. I think if we wanted to go with some sort of definition of medical necessity, I think we would have to actually publish that in a proposed rule, giving a chance for comment, and actually make that an official definition for CMS purposes as part of a final regulation.

So, it's really something right now – and I don't think that will ever be done, to tell you the truth – but because that's something right now that is left to the judgment of physicians, and different physicians, depending on different cases, depending on different situations, might see medical necessity for an admission, whether to an IRF or to a skilled nursing facility, an acute care facility for various reasons. I think that you could almost have to write, like, a whole chapter about medical necessity.

Maria Guerrero: Thank you.

Pete Diaz: I looked at both my physicians who are here right now, and they're shaking their heads yes.

Operator: We'll go next to Karen Lance with Medical College of Ohio.

Karen Lance: My question is – I think it's slide 17 – they're not numbered the way I printed them – but how is the FI going to determine if you're at 50 percent, because we know we currently aren't. Are we supposed to tell them or how does that work?

Pete Diaz: Well, there's two ways. You are supposed to – if you know that you're below the percentage – you're supposed to notify them, but right now there's really no penalty associated with that. There is a requirement to do it, but if you don't do it, there's no specific penalty associated with it as a requirement.

Now, as far as determination, number one, it is the presumptive method. Like I said, they're going to go to this QIES website, they're going to produce that report, they're going to use the instructions that I issued as to how to interpret and use that report and come up to a determination as to whether your facility met the 50 percent or not.

If, using that computerized method, your facility did not meet the 50 percent, then the FI must – it's not an option – they must go to method number two, and that's getting a random sample of medical records and using that random sample to determine if your facility met the 50 percent. That's how it's done.

Karen Lance: Now, is that an onsite review, or will we be sending them things?

Pete Diaz: No, you'll be sending them things.

Karen Lance: And all our information is on QIES, so they can tell us if we're at 50 percent or not?

Pete Diaz: Well, what's on QIES is when you – when you were filling out the IRF PAI initially – you know, during the year you were doing these assessments of patients and you were sending them in to us. And it went to one centralized site. Specifically it went to the Iowa Foundation for Medical Care – that's ...

Karen Lance: That's just Medicare patients, correct?

Pete Diaz: Right, that's the Medicare Part A patients, and one of the things I mentioned before is that the presumptive method will be based only on Medicare Part A fee-for-service patients, and I mentioned why.

So that's what's happens is we're using your data that you sent in during a certain time period to see what codes that was being recorded on those records and to take a subset of those codes to make a determination as to whether you met this compliance percentage or not.

Karen Lance: Right, and I understand that, but if we're not at 50 percent, they shouldn't be looking at QIES, correct?

Pete Diaz: No, no, the QIES is simply the website place it's a website – in other words, QIES is a – just the special website that they go to. That's how they – that's how they can – using that website, that's how they can generate the report.

Karen Lance: Right. But it's not going to tell them that I'm not at 50 – I'm using 50 percent for the Medicare percentage, not for my compliance threshold. I'm sorry for the confusion with the 50 percent.

Pete Diaz: Right. When they go there, they generate the report – Bob, maybe you can make it clear.

Bob Kuhl: This is Bob Kuhl. You're talking about the 50 percent of Medicare patients?

Karen Lance: I'm talking about my payer mix, not my compliance threshold.

Bob Kuhl: Right, right. You're talking about the – in order to the do the presumptive touch, you must have 50 percent of your patients must be Medicare patients.

Karen Lance: Correct. So what's – how do I tell – I just send them a letter saying, I'm not at 50 percent? Is there some format we're supposed to be following, or ...

Pete Diaz: ... I understand your question now. One of the CRs basically says that, in order for the FI to make that determination as to whether 50 percent of your patients are Medicare Part A or not, that they have to first ask you for certain information, and it tells them what they have to ask you for. And so, they're going to be asking your information about the patients that were in your facility during the compliance review period.

Karen Lance: OK, because we're July 1, so they'll be asking us very soon then if our payer mix will allow presumptive eligibility?

Pete Diaz: Right. They've got to – they've have to first get that listing and what they're going to be asking you for is for every patient that was in your facility during that compliance review period, the CR technically says that the admissions, but it also has a line at the bottom that says they can ask for – other than admissions, they can use other parameters. And the reason that's important is, if you look at CR 3704, which is Program Transmittal 478, it says that you, as the provider, have the opportunity to tell the FI whether you want your admissions during that time period to be used to make the determination or you want your discharges.

And for the FI to – let's say you want to use discharges instead of your admissions – the FI has to know every patient that was in that facility during that time period and know when they were admitted and know when they were discharged, but that that information is contained, (like I said), in CR 3704, which is Program Transmittal 478, and it talks about, you know, you have this option to tell the FI whether you want admissions or discharges to be used.

Karen Lance: OK. So we should just wait for our packet from the FI?

Pete Diaz: Yes.

Karen Lance: Thank you.



Robin Phillips: Next question please.

Operator: We'll go next to Kevin Davis, Memorial Health Care.

Kevin Davis: Hi. We have a quick question. Hip fracture that result in an ORIF, is that coded – I'm sorry – it results in a THA. Is that coded as a hip fracture still or is that now a joint replacement?

Pete Diaz: Coded where?

Kevin Davis: On the ...

Pete Diaz: Are you talking about coding on the – are you talking about coding on the PAI?

Kevin Davis: I mean, as far as qualifying underneath our compliance threshold – that particular patient comes in with a hip fracture, but the surgeon, instead of doing an ORIF, opts to do a THA.

Pete Diaz: Yes. Yes.

Kevin Davis: ... under, you know, a hip replacement, or is he still a qualifying hip fracture patient?

Pete Diaz: OK. It's all going to depend – you know, if there's a code like that in the Appendix A of the CRs that matches the code that you recorded in the PAI for one of those categories, impairment group, comorbidity or etiologic diagnosis, presumptively there's been a match made and that patient is counted.

Now, let's say there isn't one of those codes in there, then it goes to the – like I said before – the FI reading a random sample of selected portions of the medical record and using their – the FI

staff, using their medical training and education, getting a picture of the patient and making a decision as to whether that case should be counted over there or not. So, the FI is going to be looking to see, OK, this is what went on with this patient while the patient was in the rehab facility, what were they being rehabbed for? Does there seem to be an indication that there was medical necessity for the patient being admitted to the rehab facility in the first place, as a judgment call, and if there seemed to be medical necessity for at least the patient being there, did they have something that looks like counts towards one of those 13 conditions.

That's the only way I can answer that question, and the thing is, I mentioned before, we gave discretion to the FIs to make those decisions for themselves.

That's – the only way you can have a more definitive answer to that question is, talk to your specific FI and see what their judgment is going to be, or what their judgment would be in certain situations.

Kevin Davis: OK. Thanks.

Pete Diaz: And in fact – in fact, as I said in the last call, I highly encourage providers to start a dialogue with their fiscal intermediaries. I think if I were a provider, I would want to find out how the people that are going to be doing my reviews – what their thinking is on certain things, who are going to be the people – who will I be able to contact, maybe I need to talk to these people, maybe we need to have a conversation about some things that are kind of unique in my facility, things of that nature.

So, I really think you should really – not just you, I'm talking about everybody – should be making efforts to contact your FI staff and get that type of information. I told the FIs that, if they have some questions that they can't seem answer, that they're free to call me, and I'll definitely try to give them an answer as to whatever question that they have.

But what I wanted first is for the providers to go to their FIs and ask their questions. Let's face it, these are the folks that are going to be making your compliance determinations.

Kevin Davis: Thanks.

Operator: We'll go next to Ken Alexander, Health South Rehabilitation Hospital of Vedo

Ken Alexander: Yes. This is Ken Alexander with Health South Rehab Hospital of Baton Rouge, Louisiana, and I have a question regarding retroactive enforcement, or is – would there be – what is the enforcement when and if the moratorium is lifted?

For example, currently we are in our 50 percent year, our first year, which started September of '04. Will enforcement be retroactive to the beginning of the period if and when the moratorium is lifted, let's say, next week or next month, or would it start upon the lifting of the moratorium, creating an abbreviated enforceable 50 percent year?

Pete Diaz: As far as – as far as I know, management here hasn't addressed that particular issue.

However, my recommendation would be that, if we were to lift the moratorium, let's say, next week or two weeks from now, or at the beginning of May, and if we didn't have to change anything whatsoever due to the GAO report, that enforcement would be like we never had the moratorium in place in the first place.

But that's not a decision that's up to me. That would be my recommendation, and when that occurs, that will be my recommendation to management.

Ken Alexander: Well, that's our current assumption but, you know, I kind of like the thought of the other answer, so I just thought I'd go there. Thank you.

Pete Diaz: I understand.

Operator: We'll go now to Mary Fischer, Beth Israel Medical Center.

Mary Fischer: Oh, thank you. We're just again talking about the amputee requirement. It's not 100 percent clear to us. Is it still up to our FI, you know, if we have a patient with a transmetatarsal amputation, do we know if that's going to count? I have a second question also.

Pete Diaz: Yes, as far as that question is, if it's not – if it's not one of the codes in Appendix A then that determination would be made by your FI when they read the medical records.

Mary Fischer: OK. Thank you. And then my second question, if you don't mind – it will be quick, I hope – the presumptive method that we've been talking about, if – we do have – we qualify in terms of 50 percent or more of our patients being Medicare Part A, and so, if when our FI reviews us – and like the other gentleman, we're September – started in September 2004, so I guess they'll be reviewing us after September 2005 – if they find that we're in compliance with our Medicare Part A patients, we can assume that they will not then do a review of our total population?

Pete Diaz: I can't speak for your FI as to whether they would go further. They don't – like I said, they don't have to. They may if they want to. They can still read a random sample of medical records to actually make the determination. They're not required to, but they may.

One thing that I wanted to address though, just to make sure that I understood how you set up the question, you said your first cost reporting period started on September 1, 2004, so right now your facility is under the regulation, the compliance percentage you're having to meet right now is 50 percent, and on September 1, 2005, what you will have to meet is 60 percent.

So – and if your cost reporting period started on September 1, 2004, basically four months before that time period is when your compliance review period ends, because we needed to allow a certain amount of time for the ROs and the FIs to do all the things that they need to do, like read medical records to make compliance determinations. And we felt that they needed about four months period of time to do all the work that they needed to do so that the Regional Office, before the next cost reporting period starts, could send you something in writing saying, yes, you're still classified as an inpatient rehab facility, or we're sorry, for the next cost reporting period if you still want to participate in the Medicare program, you're going to have to participate, for example, as an acute care hospital instead and be paid under the inpatient prospective payment system instead.

Mary Fischer: So you're talking about – so May of this year is four months before September ...

Pete Diaz: Yes, September – that would be August, July, June, May – yes, so – it would be May, June, July and August – that's the time period that the FIs and the ROs have to do all their work so that by September 1, 2005 – before that time, because your facility needs to be told before that time so you can make any changes you might need to make – as to whether your facility will still be classified as an inpatient rehab facility.

That's why – by the way, that's why we created the concept of the compliance review period. We wanted to capture 12 months' worth of data whenever possible, and its not always possible, but in most cases it is. We wanted to capture 12 months' worth of data. But we realized that the FI's and the ROs have to do a lot of things before that time period, and so that's why we created a compliance review period in order to allow us to, whenever possible, capture 12 months' worth of data, but at the same time give the ROs and the FIs enough time to do what they needed to do.

Mary Fischer: OK. So, just so I understand, sorry to belabor this ...

Pete Diaz: No problem.

Mary Fischer: ... the our FI will be likely reviewing our data from September '04 ...

Pete Diaz: ... during the months of May, June, July and August.

Mary Fischer: They'll get back to us about – yes, about how we're doing. OK.

Pete Diaz: Correct. But sometime in August they should be letting you know what the decision was.

Mary Fischer: And if we're in compliance with our Medicare Part A – we'll – we have to ask our FI about that. OK. Thank you.

Pete Diaz: OK.

Operator: We'll go next to David Ackerman, Rehab Center of Cape Islands.

David Ackerman: Hello, this is David Ackerman from the Rehabilitation Hospital of the Cape Islands. I have a question with regard to the sampling methodology that will be used if you fail the presumptive method or aren't eligible for it. How are the sample sizes going to be determined?

Secondly, does a provider have the opportunity to ask for 100 percent review, especially if they're a small provider?

And just a third question, if you will – why is the access to the QIES restricted to providers? I should think that we'd be able to test our own data in the same method that intermediaries are going to be testing it.

Pete Diaz: OK. Let me answer the last question first as far as why that's a restricted website. That website, when you get into it – you know, that's the database for everybody, and there's – first of all, there's some privacy concerns. When we set this up for the FIs as far as accessing that website, we had to go through a lot of processes to make sure that even when the FIs access that website, the only – the only information that they are able to see is for the inpatient rehab facility to send that FI actual claims because they're authorized to see that kind of information.

Obviously that would be a much bigger problem if we opened that up to the general public. That's the reason right there.

Number two is, the information that's in that website, you have at your facility. That's the information that you transmitted to us in the first place, and from the inception of the IRF PPS, there's a regulation that says that you're required to keep that information at your own facility for a minimum of five years in a format that's readily accessible. In other words ...

David Ackerman: It's the testing algorithm that we're most concerned with. We've heard indications from other providers that – in our group that their methodology for satisfying the presumptive rules isn't matching up with what the FIs are determining.

Pete Diaz: Yes, I've heard that also, and actually I've contacted the person constructed the software, and I asked him to double-check because I told him that probably in the near future somebody would probably ask for the actual codes that are in the software, and we could make that available because all I did was send to that software person the appendix. That's all I ...

David Ackerman: Yes, that would be very helpful.

Pete Diaz: ... these codes. Now, the other – you'll have to refresh my memory on the other questions you asked.

David Ackerman: Sample size or how the sample size is going to be determined when sampling is used...

Pete Diaz: Ok, that, yes, all I said was in there that the FIs have to use random – generally accepted, random sample statistical method, so for that, whenever a statistician or somebody with that kind of training at the FI would have to come up with what's random sampling method for that particular case, and if you can ...

David Ackerman: So, nothings to prescribed in the CMS instructions to the FI.

Pete Diaz: No, no, we just said to use generally accepted random sampling methods, and you can ask the FI about that, you can ask what random sampling techniques they use. They should be able to able...

David Ackerman: I mean, there are confidence levels and so forth that will determine the size and ...

Pete Diaz: ... that is – we did talk about confidence level and the CR, and as far as for a small facility, actually one of the physicians here had something put in the CR and what it says is, if the sample size is 100 records or less, all 100 records will be used to determine compliance if you're reading medical records.

David Ackerman: That is really small.

Pete Diaz: Yes.

David Ackerman: OK. Thank you.



Pete Diaz: OK.

Operator: We'll go next to Melanie Good, Mercy Rehabilitation Center.

Melanie Good: Our question has been answered, thank you.

Operator: We'll go now to Jennifer Wilson, University Hospital.

Jennifer Wilson: Hi. I just had a question about recreation therapy and if it's automatically included in the three hours, or do you have to justify first why you're not able to give three hours of PT and OT ...

Pete Diaz: Yes. Recreational therapy is really not one of the subjects of this call. We're talking about the 75 percent rule. I'm well aware of the recreational therapy is an issue that's in controversy. We get some letters here about that issue. But I really don't want to address recreational therapy during this call. I'll ask Bob, is there anything that we think that we should ...

Bob Kuhl: No, I don't think so at this point. In terms of – I guess her question is in terms of the ...

Pete Diaz: Three hour therapy guideline, yes. Yes. Yes, we had – we get letters in here that we respond to, and in general what we have said so far, as you're probably well aware, that we don't believe that it can be used to the three-hour therapy guideline. I mean, that's the general gist of what we have said so far. But that's really not something that we want to get into during this call.

Jennifer Wilson: Thank you.

Operator: We'll go now to Nancy Call, North Oakes Medical Center.

Nancy Call: Hi. Good afternoon. I have a question. Can you hear me?

Pete Diaz: Yes.

Robin Phillips: Yes.

Nancy Call: OK. I just wanted to make sure. I currently have two facilities. One is an acute care hospital; the other is a rehabilitation hospital. We are attempting to combine the two facilities into one to eliminate the duplication of costs reports and other various charges. I am very confused as to what I need to do. I have gotten very little guidance from my fiscal intermediary. I am currently exempt from inpatient prospective payment system, and I meet all the criteria for an IRF. They are telling me that I have to go back and get provider-based status in order to maintain my qualification as being paid under CMGs. Is that true?

Pete Diaz: So you're – you've got two facilities that are combining into one?

Nancy Call: Right, owned by the same public service district.

Pete Diaz: OK. And your question is how will the 75 percent rule determination be made, is that your question?

Nancy Call: I already have that. I'm already an IRF.

Pete Diaz: OK. So your question is something about the requirements that have to be met or something like that?

Nancy Call: Right. What I'm getting from my fiscal intermediary is that, in order to do this, I have to be a provider-based IRF, and currently there's a moratorium on coming up with decisions whether or not an IRF meets provider-based status. And they're telling me that I can't do this.

Can you guys provide any guidance or ...

Bob Kuhl: I think the best thing to do is to maybe write something in to us.

Robin Phillips: Yes. How if you – this is Robin – how about if you send your questions to our contractor training e-mail box.

Nancy Call: OK. How do I do that?

Robin Phillips: And that's contractortraining – all one word – @cms.hhs.gov.

Pete Diaz: I want to also say one other thing, though. Have you contacted your Regional Office?

Nancy Call: Yes, sir. They have told me that I cannot do it because they are not reviewing provider-based applications for IRFs.

Pete Diaz: Well, if you've contacted your Regional Office, you have gotten the CMS response basically at that point, because those types of decisions are made by the Regional Office staff, and when we get – you know, that's why I asked – when we get that type of question here, we just identify which Regional Office handles that and send it down to them to make a decision, but you said you've already talked to them.

Nancy Call: But, I mean, isn't there some kind of loophole – I mean, I'm already an IRF. I already have that designation. I already meet the 75 percent rule and everything else. All I'm trying to do is combine my two entities.

Pete Diaz: Yes. They're the ones that handle all the operational type requirements and they're the ones that are the experts on that. I am not, on a call like this, without having a lot of information in front of me, even – would even say anything contrary to what they've told you because they might have some very good reasons for their decision.

So, you are – you can either send a letter, you know, if you're dissatisfied with what the Regional Office told you, and they're CMS, so that's all CMS. If you're dissatisfied, you can send a letter to the either the regional administrator or the Secretary of Health and Human Services or the Administrator of CMS, and articulate your point and say why you think this is unjust or unfair. But as far as the decision that--that is made about, that is made by the Regional Office staff.

Nancy Call: OK. Thank you.

Operator: We'll go next to Dharma Mirabent, Mt. Sinai Medical Center – Miami Beach, Florida.

Dharma Mirabent: Hi. Good afternoon. My question is similar to this one, however we did have – we are increasing the number of beds to our inpatient rehabilitation unit. We already have approval from our state, and I see on this presentation that you can only change classification of a unit in the beginning of a cost reporting period. Does this apply for the addition of new beds after they have been approved through our state process?

Pete Diaz: Yes. You can only change those kind of things at the beginning of a cost reporting period.

Dharma Mirabent: OK. Thank you.

Operator: We'll go next to Stephanie Karn, United Health Center. Ms. Karn, your line is open, please go ahead.

We'll continue on to Jay Flaherty, Paradise Valley Hospital.

Jay Flaherty: Hi. A question about comorbidities. I'm looking at Appendix B of the latest IRF PAI training manual 040104. Occasionally we encounter a patient who has an impairment code, and I'll give you an example – 03.3, polyneuropathy. The ICD-9 code that we come up with falls in between some of the numbers here. For instance, the offerings are hereditary or idiopathic or toxic, and we often have patients with diabetic polyneuropathies. Are we safe to go ahead and admit that person under polyneuropathy and use the codes that we have, even though it's not on the list?

Pete Diaz: Well, when you say ((inaudible)) that the patient, first of all, does the patient have medical necessity to be in the inpatient rehab facility in the first place. Let's make the assumption that that case is yes. Then what I think what you're really asking is, does that particular code on Appendix B of the IRF PAI manual, would that be considered a code that matches one of the medical conditions?

And I revert to the answer I gave you before, which is, if a specific code is not listed on Appendix A of the CRs, then whether a case matches or not could be based on a code, it could be based on something other than the code, and the decision will be made when the FI staff reads selected portions of the medical record.

So, unless one of the specific codes that you have in mind – unless you see that on the Appendix A list, unless you – if you see that there, then you can make a presumption that looks like the match would be made. If you don't see it there, then you're going to be dependent upon what the judgment is of your FI when they're reading your medical records.

Jay Flaherty: Well, Appendix A is the easy part, because it's basically the impairment codes. Where it gets difficult is substantiating with an ICD-9, which is in Appendix B.

Pete Diaz: Yes, but I think that you're misreading one thing. Appendix A has the impairment group codes, and it also has a listing of ICD-9 codes that either are the etiologic diagnosis code for the comorbidity codes. There's a listing of both.

What I said before was a case can meet one of the medical conditions if either the impairment group code or the comorbidity code or the etiologic diagnosis code that's listed in Appendix A – if it's listed there, then there's a presumption that that particular case has met one of the medical conditions.

So in that sense, yes, that's the easy way of doing things. If it's not on there, then it doesn't meet one of the medical conditions, but once again, if your inpatient rehab facility doesn't meet the compliance percentage based on that, then the FIs have to go to method number two, which is reading of medical records.

So, you're not going to have all the codes that you or somebody else thinks maybe is appropriate on that code list. That code list was constructed purposely to be very restrictive, and just because you failed based on the code list doesn't mean that you don't get another shot at meeting compliance. You do get another shot.

Jay Flaherty: OK. Let me sneak in another quickie. Hip fracture is listed as a 13, one of the 13 diagnoses that I keep seeing pieces saying that CMS would prefer patients with hip fracture to go to SNFs.

Pete Diaz: And your question is?

Jay Flaherty: And we admit hip fractures to inpatient rehab.

Pete Diaz: Hip fractures is one of the conditions on the list. I mean, it's one of the clear conditions that's been there from the beginning. So all you really would have to meet at that point as to whether that patient had medical necessity to be in an inpatient rehab facility in the first place. But hip fracture is one of the clear conditions on the list.

Jay Flaherty: Thank you.

Operator: We'll go next to Katherine Buckley, Hospital of St. Raphael.

Jonathan Bright: Good afternoon. I'm Jonathan Bright speaking for Kathy, and I have two questions.

One was on Transmittal 347, when you look at Section 140.11, "Criteria That Must Be Met By Inpatient Rehab Hospitals," one of the criteria is that the hospital has a Director of Rehabilitation who provides services to the hospital and its inpatients on a full-time basis.

I was wondering if you could define that. And secondly, is speech therapy included in the three-hour rule? I know it's somewhat off topic, but it's germane in this time of shortage of physical therapists and occupational therapists. Thanks.

Pete Diaz: OK. Speech therapy is one of the things that is mentioned in the three-hour therapy guideline if a patient has medical necessity for that. That's one of the things that's clearly listed in there, so that should answer that question.

So if the patient has medical necessity for speech therapy and that's documented by the physician and everything, and they get three-hours of therapy and it includes speech therapy, you've met the three-hour therapy guideline for that as far as speech. But your other question as far as full-time, I think what you're asking and – let me ask you – are you asking what the definition of full-time is?

Jonathan Bright: Yes.

Pete Diaz: OK. This question is asked a lot. Full-time, we'll accept different ways of looking at it. You know, obviously 40 hours a week is full-time in most places. But let's say, for example, a facility operates so that their personnel are considered full-time and this happens in some places that are only working 36 hours a week. OK. So if everybody there is working 36 hours a week and is considered full-time – then if the medical director only works 36 hours a week, we'll consider that to be full-time.

Another way of looking at it would be – in case there's any question – if a state says hey, according to our state regulations, 36 hours is full-time or 38 hours is full-time, we'll accept that. We're not going to, you know – we're not going to quibble with states on their regulations and things of that nature and come up with a different definition of full-time. Does that answer your question?

Jonathan Bright: Yes, but one more clarification. Does that include Part A and Part B services, or just Part A, or combination of?

Pete Diaz: No, no. What we're – what I'm talking about was the requirement for an inpatient rehab facility to have a Director of Rehabilitation in the hospital, and if that facility is a hospital – a freestanding hospital – that they have a full-time Medical Director.

That's what I was talking about. In that sense, what I'm talking about is something that's provided under Part A, because it is – that requirement is a IRF PPS requirement, and the IRF PPS is only a Part A payment program.

Jonathan Bright: Thank you.



Operator: We'll go now to Kathy Soosik, St. Joseph Mercy.

(Ellen Petty Bronon: Hi. This is Ellen Petty Bronon in for the Kathy. My question is, how difficult is it to reconvert a rehab bed back to acute med/surg bed and what is the process?

Pete Diaz: Oh. Well, the survey and cert person that I heard there before, Georgia Johnson, would be best to answer that question. That's – I don't know what all the requirements are to be met by an acute care hospital, I'm not in survey and certification, but if you want the answer to that question, there's no problem.

Just contact your Regional Office. Each Regional Office has survey and certification staff. If you go to the CMS website, look around a little bit and you'll find a listing for Regional Offices. It lists what states are covered by a Regional Office.

Then your next question would probably be, who do I contact at the Regional Office? If you can't find a specific name, what I've actually told people is – and I tell this when people call me up – call up the Regional Administrative Office.

Obviously, one of that person's staff members is going to answer the phone. They're going to know what your question is. They're going to know who are the survey and cert staff in that Regional Office, and they'll be able to provide you one or more names in survey and cert and that could answer that question for you.

Ellen Petty Bronon: Thank you.

Operator: We'll go now to Sandy Harrison, Northern California Rehab Hospital.

Sandy Harrison: Good afternoon. I needed to clarify on a review period. We have a fiscal year that ends on May 1, so I wanted to find out from you what the review period would be for our facility and go from there.

Pete Diaz: So your fiscal year ends on May 1 instead of like most fiscal years ending at the end of the month.

Sandy Harrison: Correct.

Pete Diaz: OK. Yes, the FI and the Regional Offices is just going to have to do a slight adjustment in the tables. In other words, they're going to have to adjust it by what – May – we're talking about one day – so you could just envision that table that's in the CR as being shifted over by one day.

So the compliance – but the compliance review period – your cost reporting period starts on May the first – oh I see – there's no shifting involved, yes. I'm sorry, but I take that back. Your cost reporting period you said starts on May the 1, right?

Sandy Harrison: Correct.

Pete Diaz: OK.

Sandy Harrison: And that ties in with the fiscal year, correct?

Pete Diaz: OK. Right. OK. So, I thought you had another situation which is, we have a few facilities that cost reporting periods don't start right on the first of the month, so excuse what I just said before.

Sandy Harrison: OK.

Pete Diaz: But, if your cost reporting period starts on May the 1, your compliance review period actually ends four months prior to that period of time. So four months ...

Sandy Harrison: We're looking at December ...

Pete Diaz: ... would be April, March, February, January – so your compliance review period would be ending on December the 31st, in this case December 31, 2004. But you're a May 1 provider, so you're actually only being hit by the 50 percent rule for the first time on May 1 of this year.

In other words, you're not coming – you're not coming under the regulations the first time until May 1 of this year, because as I stated earlier what the regulation says that it's for cost reporting periods starting on or after. So for cost reporting periods starting on or after July 1, 2004, you're cost reporting period in that case starts on May 1, 2005. So your compliance review period will be in – ending at the end of this year, December 31, 2005, in order to allow January, February, March and April of 2006 to be your compliance review period.

Sandy Harrison: So at – prior then what would be the compliance percentage that I would need to comply with – 75 percent or?

Pete Diaz: No. Actually right – you're just like everybody else before you got affected by the regulation. For example, because we had—we did two things before 2004 and – before 2004, which is we had suspended enforcement and we also changed the percentage amounts.

But what we did was we just, for everybody, started the clock new for the first time some, you know – in almost all cases. There's a few exceptions if you're going through the conversion process, but that's like one percent of the cases or less. But everybody just had the clock started all over again as far as percentage amounts and time used and everything starting on July 1, 2004 forward.

So anything before May 1, 2005, you don't have a compliance percentage that you have to meet and you don't – you know, anything of that nature. That was the same case for facilities for example that had a July 1, 2004 cost reporting period. For the time before that, you know, we're not looking at anything there. Does that answer your question?

Sandy Harrison: The very last statement you made, cost reporting periods beginning July 1, I understand and they have the review period of July 1 through February 28, 2005, is that correct?

Pete Diaz: Yes. If an IRF had a cost reporting period that started right on July 1, 2004, their compliance review period would end on February 28, 2005.

Sandy Harrison: OK.

Pete Diaz: So there's two things you have to think about together. Number one is, when you have to – when are you affected by the regulations requiring? That's number one. So that's why that phrase for cost reporting periods starting on or after July whatever – you know, if it's 2004, 2005, 2006 – that's why that phrase is so important. And in your case, when you gave me an example about May 1, 2005 being your cost reporting period, that's when – for that time forward is when you're having to meet 50 percent.

Before that you're just like folks before – you know, let's say you had a cost reporting period that started on October 1, 2005. Before that time, the same thing. There was no percentage the way we did things that had to be met anymore. You know, everybody got a fresh start all over again was the effect of everything.

Sandy Harrison: OK. But our facility was in operation of May 1, 2004, so ...

Pete Diaz: Well, your facility was in operation ...

Sandy Harrison: OK.

Pete Diaz: ... but as far as the regulations concerned, since your cost reporting period had already started on May 1, 2004, you were in the midst of a cost reporting period when July 1, 2004 came about.

Sandy Harrison: OK.

Pete Diaz: We – so, you know – that's why that phrase "for cost reporting periods starting on or after July 1, 2004" – that's what that means. When did your cost reporting period start in relation to that phrase? It starts – it's going to start now on May 1, 2005. That's why that's the first time that you're being affected by the rule.

Sandy Harrison: OK. And so will it go then from May through December, correct?

Pete Diaz: Well, your cost reporting period will start on May 1, 2005, and your compliance review period will have started – remember there are two things. I mentioned it during the slides. Your compliance review period will have started on January 1 of this year, of 2005.

And it ends on December the 31st of 2005 – so that between January 1, 2006 and April 30, 2006, the RO and the FI do everything that they need to do to see if on May 1, 2006, your facility still qualifies as – to be classified as an inpatient rehab facility. But ...

Sandy Harrison: Thank you.

Pete Diaz: ... just look at the CRs it's – the information is in there like that, but – and you can also ask your FIs these same types of questions. If they're not able to answer them with this kind of specificity, just have them call me instead.

Sandy Harrison: Great. Thank you.

Operator: We'll go next to John Kassabian, Boston Medical Center.

Robin Phillips: Hello?

Operator: We'll go next to Lindo Belford, Hurley Medical Center.

Lindo Belford: Hi. My question's already been answered. Thank you.

Operator: We'll go next to Linda Lattner, St. Claire Hospital.

Betty Saroka: Hi. This is Betty Saroka, and I'm calling just to understand the compliance issue under the presumptive format. If I have 50 percent of our patients admitted to IRU and they are Medicare, I can assume then that they will be reviewed under the presumptive method. However, if the other 50 percent are managed care, will they not be included in the review, or will they be included in a random sample also?

Pete Diaz: Yes. Let's say that 50 percent or more of your patients are Medicare Part A fee-for-service patients. OK. So when the presumptive method is used, that's going to be the only population that's going to be used for the presumptive method, because those are the only data records that you've had – that your facility had to submit to the contractor, so that's what's in the database.

If your FI has to use the random sample reading of selected portions of medical records, then what they're going to use instead is any patient that falls in that random sample. In other words, if you have Medicaid patients, private pay patients, charity cases, workmen's comp or what have you – if one of those cases falls in that random sample, that would be one of the cases that would be used to make the determination.

But that's if when the patient – when the FI rather – when the FI reads medical records, the presumptive method, all they're going to use is just your Medicare Part A fee-for-service patients because that's what's basically in your database and that's how the system is built.

In other words, the FI – when they're using the presumptive method, there's no option. It's a centralized software. The – you know, they've just got to press a few buttons and the report is going to come from the IRF PAI database. And the programmer that built that program according to my guidance, which said use only the Medicare Part A data records in there as part of the program.

Betty Saroka: If I'm 50 percent or more, that's what they'll use? They won't look at the others that might be managed care or other payers?

Pete Diaz: No. What I've said is that they can make a presumptive determination based on their population. However, I said that they don't have to stop there. If they want to they can stop there, but if they for whatever reason – if they want to go method number two – that they have that discretion. In other words, whether you meet the compliance percentage or not based on the presumptive method, the FI has the discretion if they want to, to go to method number two. They don't have to, but they may.

Robin Phillips: Did that answer your question?

Betty Saroka: Thank you. Yes, it does. Thank you.

Robin Phillips: Thank you. Next question, please.

Operator: We'll go now to Maggie Moore, Washoe Medical Center.

Maggie Moore: Our question has been answered. Thank you.

Operator: And ladies and gentlemen, if you find that your question has been answered, you may remove yourself by pressing star two. Again, to remove yourself it is star two. We'll go next to Kimberly Allen, North Oakland Medical Center.

Kimberly Allen: Good afternoon. My question is about the compliance software program that you're going to be using. Now, am I correct to assume that if something is coded with an RIC code of a knee replacement, that's going to be acceptable under the 75/25 compliance rule?

Pete Diaz: No. If there's a code that – in that data record that's being examined by the software that matches one of the codes that are mentioned in Appendix A of the CRs, and if it matches, that's one of the codes that's going to be used to make that determination. So it depends on what code is in there that you already submitted, if it's – that you already submitted, and whether it matches one of the codes in that Appendix A.

In other words, if you want to see whether a specific code is in there, just go to Appendix A, go to either column two or column number three, and look at the code list. And that will tell you if one of those codes is going to be used to make that presumptive determination.



Kimberly Allen: OK, but help me here then, because I'm looking at your – the 13. And one of the codes is – sorry, it wasn't for joint replacement – severe or advanced osteoarthritis – so that is inclusive?

Pete Diaz: Is it a code appearing in Appendix A?

Kimberly Allen: You know what? I'm sorry, I don't have that in front of me. I'm looking again ...

Pete Diaz: Because that's the only ...

Kimberly Allen: ... at your slides.

Pete Diaz: That's the only way I can answer your question because right now I could not – there's at least a couple hundred codes in that listing, and you can go to that listing yourself and see if you find that code. That's really the answer to your question.

Kimberly Allen: Right, but – then again, help me to clarify. Now I thought you said that it was either one of the RICs, correct? Or ...

Pete Diaz: No, I ...

Kimberly Allen: ... the co-morbidity, or a ...

Pete Diaz: Not one of the RICs. I said one of the impairment group codes. The RIC is a higher level. That's the Rehabilitation Impairment Category.

Kimberly Allen: OK.

Pete Diaz: But I said it's either one of the rehabilitation impairment group codes or one of the ICD-9 codes that matches one of the etiologic diagnosis codes on the PAI record, or one of the comorbidity codes.

Kimberly Allen: OK. So, on your PowerPoint slide, you are calling severe, advanced osteoarthritis one of the 13, as long as it's qualified by the therapy prior to or blah, blah, blah. Does that match up with the impairment group of 6.2, osteoarthritis?

Pete Diaz: Some of them – some of them do. You'll find the codes for the arthritis-like conditions in Appendix A to be very restrictive, but I don't know which code right now in front of me – in other words, I don't – I didn't construct the code list.

And I don't have an ICD-9 book or – in front of me, and I don't have the listing right now of the impairment group codes. If you go to the IRF PAI manual, you can get the listing of the impairment group codes and they say what type of medical condition that is – that is talking about...

Kimberly Allen: Yes.

Pete Diaz: ... if you – if you are interested in what the ICD-9 code stands for, you need to go to one of the ICD-9 code books and see what that matches up as far as in the book.

Kimberly Allen: OK. Again, thank you. I'm following you so far, but the – in – earlier you said the impairment group would be included in the software that you were referring to with QIES ...

Pete Diaz: Right. What I said was we had the code list constructed using the codes from Appendix A. That's how that code list ...

Kimberly Allen: Only from Appendix A, then?

Pete Diaz: Right. The code list from Appendix A ...

Kimberly Allen: OK. Sorry.

Pete Diaz: ... is what's built into the software. Yes. All I did was – what I did was send the programmer  
– literally what I did was I sent the programmer Appendix A.

Kimberly Allen: OK. So the impairment groups are not included in the compliance software?

Pete Diaz: The impairment groups are included in the compliance software, because if you look at  
Appendix A, you'll see that one of the columns clearly is labeled Rehabilitation Impairment Group  
codes. I think you need to look at – I think you need to look at Appendix A.

And if you look at Appendix A, right from the very first page you'll see that there's a table that  
says "Medical Condition." Column number two reads "Rehabilitation Impairment Group Codes,"  
and column number three reads "ICD-9 codes."

Kimberly Allen: Right. But what I'm saying is, you can put an impairment group code of something and  
not have it match one of the ICD-9 codes. We've determined that, correct?

Pete Diaz: You can put an impairment group code and not have it match one of the ICD-9 codes?

Kimberly Allen: Correct.

Pete Diaz: I don't understand your question. I'm sorry.

Kimberly Allen: You can call something a neuropathy, but diabetic neuropathy is not one of the included ICD-9 codes.

Pete Diaz: Right. There's going to be some codes that stand for the condition that you just specified, but that particular code may not be on the code list in Appendix A.

Kimberly Allen: Right. So are you saying that it has to meet the impairment group and the ICD-9 code that matches it?

Pete Diaz: No. I said initially – it's on the slide and it's also in the paragraph right before the code list. I said one or the other or the other. That's what I said, I said the word or.

Kimberly Allen: Or – OK. OK. Very good. Thank you.

Robin Phillips: Thank you. Jamie, can we find out how many questions we still have in the queue, please.

Operator: We are standing by with approximately 30 questions left.

Robin Phillips: OK. I would really like to let everyone know that they need to limit their questions to one so we can try to get everyone's questions answered today. Next question please.

Operator: We'll go now to Pauline Osborne, Rehab Hospital of the Pacific.

Pauline Osborne: Hi. This is Pauline Osborne at Rehabilitation Hospital of the Pacific. I thought I had this cost reporting period and compliance percentage threshold period straightened out, but I'm confused after this call, so maybe we can straighten it out.

I'm looking at the fact sheet number two that was provided that had the table of compliance review periods, and our cost reporting period begins October 1, 2004, so this table of compliance review periods says that our review period will be July 1, 2004 to May 31, 2005, that's fine. That they will be looking at 11 months, and that 11 months begins July 1, and our compliance threshold is 50 percent.

Pete Diaz: Correct.

Pauline Osborne: So does that mean we have to be 50 percent compliant from July 1 or from October 1?

Pete Diaz: From July 1.

Pauline Osborne: OK. Because thought that what you said that there was the compliance threshold began on the cost reporting – beginning of the cost reporting period.

Pete Diaz: Yes. That's what sets the – that's what sets the compliance percentage itself. But then I said that there's an associated time period which is the compliance review period. And it's data that's selected from that time to see – that's going to be used to see if that percentage amount was met.

Pauline Osborne: OK. So beginning July 1, 2004, we would need to meet the 50 percent threshold?

Pete Diaz: Right. From July 1, 2004 – yes, right.

Pauline Osborne: OK. And then, I'm sorry. I do have a quick follow-up question. For the next cost reporting period where we have a 50 percent compliance for part of the cost reporting period and a 60 percent compliance for the other part – or not the cost reporting period, but the compliance review period – will they be doing two samples then, one from each compliance review period, or for, you know ...

Pete Diaz: Yes. When you get into things that start out in '05 – in other words, for anything that's after July 1 – anything on or after July 1, 2005, what you have is the compliance review period spanning two cost reporting periods ...

Pauline Osborne: Right.

Pete Diaz: So in – well – for – you know, there's going to be two percentages that are going to be met. So there's going to be one percentage that's going to be met that's, you know, for the four month period of time that's going to be that the lower compliance review period. And there's going to be a compliance review – there's going to be a percentage that's going to be met for the eight-month period of time that's going to be a higher compliance percentage.

Pauline Osborne: So rather than doing one sample, they're going to have actually be doing two separate samples?

Pete Diaz: If they ...

Pauline Osborne: But statistically valid samples.

Pete Diaz: Yes. If they use – if they use random sampling, they're going to have to – they're going to have to use two samples if they do it that way. And if they use – if they use the software, if they're using the software, the software does it automatically ...

Pauline Osborne: Yes.

Pete Diaz: ... and – but if they – if they're reading medical records, they're going to have to get two samples.

Pauline Osborne: OK. Thank you.

Operator: We'll go now to Bobbi Hunt, Crichton Rehabilitation Center.

Bobbi Hunt: Good afternoon. I have a question that was asked – a follow-up question that was asked earlier about Appendix A. In the earlier conference call that was scheduled about a month ago, Appendix A was addressed. And we received some information from our hospital organization here in Pennsylvania, and it said that an IRF should not use Appendix A for IRF PAIs, but should use the IRF PAI manual code guidance. Now does that count for the 75 percent rule compliance, as well?

Pete Diaz: No. No, what was happening was this. As you know, the IRF PAI manual has an Appendix A, B and several appendixes ...

Bobbi Hunt: Yes.

Pete Diaz: ... and as you know, the IRF PAI manual is what specifies how you fill out the IRF PAI form.

OK. That's still in use. That's what you use. That's what you use to fill out the IRF PAI itself.

And that's what – once you use that and that record is sent in, that gives for your IRF, for that time period – that gives that universal code for your particular IRF.

Then, that Appendix A from the CR does – it doesn't say fill out your IRF PAI using Appendix A from the Program Transmittal CRs. It just says, OK, you've sent us in these records and they have all these codes, and we're going to take a subset of those codes to verify compliance using the presumptive method and that subset of codes is specified in Appendix A of the CRs.

Bobbi Hunt: Right. I understand that and maybe I missed a comment. I apologize. The question at the last conference was what code list will be used for the presumptive test, and the answer was, IRF should not use the Appendix A for the IRF PAI, but should use the IRF PAI manual code for guidance.

Pete Diaz: OK. What code list will be used to determine compliance, that's your question right? OK. The code list that will be used to determine compliance using the presumptive method is Appendix A from the Change Request – what I call the CRs – that's the code list that's going to be used.

Bobbi Hunt: OK.

Pete Diaz: The code list that should be used to actually fill out the IRF PAI are the other – are the instructions and the appendixes that have codes and other things from the IRF PAI manual. So what was happening was that there had been a misinterpretation somewhere along the way that people were thinking that they should use the code list from Appendix A as their actual guidance in filling out the IRF PAI. That's not what Appendix A from CRs is meant for.

Bobbi Hunt: OK. I just have one other question, and this actually deals with Appendix A. On the latest Change Request with the latest Appendix A, the code for stroke, 436, is not included on Appendix A.

Pete Diaz: There was one code – and I think it's exactly that code – that was specified in CR 3704, which is Transmittal 478, and it's what – are you talking about code 438.40?

Bobbi Hunt: No. Code 436.

Pete Diaz: 436 – OK. Let me look at that – let me look at the code list and see if – I'm going to write – 436 you said?



Bobbi Hunt: Yes. It's a stroke.

Pete Diaz: OK. Let me look to see if maybe there's something missing in here.

Bobbi Hunt: OK. Thank you very much.

Pete Diaz: You're welcome.

Robin Phillips: Next question, please.

Operator: We'll go now to Earl Rhind, Rogers City Rehab Hospital.

Robin Phillips: Earl? Next question.

Operator: We'll go now to Deborah Brannon for the Hospital of Orlando.

Terry Bardel: This is Terry Bardel. I wanted to comment on your earlier discussion regarding the requirement to document prior therapy on some of the arthritis diagnoses in order to qualify them. What we're finding is that doesn't seem to be a realistic – there isn't a realistic way to do that.

And when you're interviewing somebody after a major surgery and then saying, can you tell me where you've had your therapy and how long it's been, let alone going out and finding the phone number to the clinic and getting the records – so – my – it's really more of a comment. I hope that you'll take that into account as you define that better, because unless you can help us with a better way to grab that information, it just doesn't seem to be realistic to paint it.

Pete Diaz: Yes, and actually we tried to take something like that into account when we wrote the conditions there in the CR, because we do have a line in each one of those in order to – in order to cover some situations like that.

And what we've said is – however there may be cases when in the FI's judgment, the preceding interpretation of what's considered an appropriate, aggressive and sustained course of outpatient therapy services or services in other less intensive settings should not be used. And then we go on to basically say, OK, if that's the case, FI you have discretion to come up with something else as long as you document it and give reasons why.

So, once again, the FIs have discretion in that, you know, if something really is unusual happening in an area for some reason, they can – they can – they can come up with another way of determining as to whether one of those arthritis-like conditions were met. It's written right there in the CR.

Terry Bardel: Right and I'm sure that's going to be necessary because at least our FI is not allowing more than one or two treatments for these types of patients in the outpatient setting because they consider it maintenance. So there really is no way to provide that standard in the State of Florida.

Pete Diaz: All right. So in that case, then the FI could definitely take that into account and use that discretion that we gave them right there in the CR to come up with another method.

Terry Bardel: OK. Thank you so much.

Pete Diaz: You're welcome.

Robin Phillips: Jamie, how many questions do we still have in the queue?

Operator: We are standing by with approximately 25.

Robin Phillips: OK. This is going to be our last question.

Operator: We'll return to Earl Rhind, Rogers City Rehab.

Earl Rhind: Thank you very much. I have a question, and I think it's really regarding the issue of medical necessity. I will give you an example of the single knee replacement – 81-year-old lady who comes in with fluid overload and she is congested. She's got an LES. She's in bladder retention. She develops phlebitis. She has – we find she's had early dementia, which is now a little worse, and overall this is a medically complex, very difficult case.

Now, so it goes to the FI. Do they have the freedom to say that this is, in fact, should be a 75-percenter, or a qualifying patient, or could they just say no, this is a 25? Do they have the freedom, with that information, to say this is so medically complex, we are going to put it as a 75 even though it doesn't meet one of the 13 criteria exactly?

Pete Diaz: That discretion they don't have, because they can only – they only have discretion to see if a case has information indicating that it matches one of those 13 broad categories. So, unless they can match one of those 13 broad categories, they just can't say, for example, medically complex matches what, stroke or major multiple trauma or burns? I mean, they've got to match it to something, so – but they can't do that. No.

They have – they have to at least try to make the match to one of the broad 13 conditions.

Earl Rhind: So, if we are at 49.51, right on the margin, and this very ill individual has a choice of going to a nursing home or coming here where they get the proper treatment, you know, I can't believe it was the intention of either your office or anyone else to put this patient over in a place where

she's not going to get adequate care. So, how do we – how do we work with this from an ethical level, if nothing else?

Pete Diaz: Well, first of all, if you're at 49.51, when I – when we issued CR 3704, you'll notice that I gave an example of doing computations, and when I gave that example, I said, OK, if you come up with this number, that's rounded up to this. So 49.51 would be rounded up to 50 because you have in a normal – what we were all taught in school are far as rounding – as far as rounding, you know, so I try to provide for that because you are going to be so close, so you wouldn't have a problem.

Let's say, for example, that you were 45 percent instead. At that point, yes, that patient, if it didn't meet one of your – one of the medical conditions and you thought this would throw you out of compliance, you would probably have to make a decision as to whether you're going to be out of compliance and no longer be classified as an IRF, or whether that patient instead – you know, if you're going to have to send that patient for treatment someplace else, like to a skilled nursing facility or some other type of place. That's the effect of the rule.

Earl Rhind: Boy. Thank you.

Robin Phillips: Thank you. I would like to remind everyone that we have an encore to this call that will begin two hours following this call for five days, and the encore number are ...

Pete Diaz: Robin, if I can interrupt for just a second.

Robin Phillips: OK.

Pete Diaz: I wanted to emphasize once again, because there are still a lot of people waiting to ask questions. Call up your fiscal intermediary staff, ask questions of them, and if they can't answer your questions, have them call me.

And the other thing is, check with your fiscal intermediary staff as to how they're going to be doing the statistical sampling type techniques.

There were some questions asked about that and I think you need to check with them exactly how they're going to do it. They're the ones that have to come up with the techniques. We just gave them some broad guidelines, and go to them with that type of question.

So, once again, I really encourage you to ask those questions of them. I'm quite happy to talk to the FI staff or the Regional Office staff and answers their questions, but there are about 1,230 inpatient rehab facilities and a number of interested parties that are interested in this rule, and at this point RO staff and FI staff have enough training to answer the vast majority of the questions, and questions that come in to me like that I am going to ask you to – I would ask that you call me up or send me an e-mail, I would ask you to contact your FI staff or RO staff instead.

Robin Phillips: Thank you, Pete. And again, we're sorry that we weren't able to answer all your calls today. The encore numbers are 1-719-457-0820 or 888-203-1112, and the pass code is 4225450.

OK. At this time I would like to thank everyone for participating on the call, and thank Pete for the presentation and his participation. And this ends our call today. Thank you.

Operator: Once again, ladies and gentlemen, that does conclude today's call. Thank you for your participation. You may disconnect at this time.

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