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Eli's Rehab Report

Inpatient Insights: Proposed IRF Rule Could Tighten 60% Rule Even More

Plus: You may see 2 new items on the IRF-PAI next year.

The **Centers for Medicare & Medicaid Services** (CMS) has released its proposed 2015 Inpatient Rehabilitation PPS rule (http://tinyurl.com/ldtk44n). The agency is planning to increase IRF payments by 2.2 percent next year, along with several other changes affecting rehab. Check out the highlights of what CMS has brewing:

1. Prepare for Scrutiny With Amputation-Only Cases

Think the 60 percent rule is tight enough as is? Think again: CMS wants to remove diagnosis codes that focus on amputations only from the presumptive compliance list.

Potential impact: The majority of amputee patients in inpatient rehab would hopefully avoid the hit because amputation is so often a secondary diagnosis and less often a standalone condition.

"We do not have definite numbers on the exact percentage of patients with amputations that comprise the IRF caseload, but we do believe it is a significant portion, mostly, as a secondary diagnosis," says **Roshunda Drummond-Dye**, director of regulatory affairs for the **American Physical Therapy Association**.

Even with a low impact, however, therapy advocates still aren't all-in with CMS' proposal to further tighten the 60 percent rule.

"Our position always is that the whole patient should be considered in determining the proper acute, post-acute or outpatient treatment ... not by arbitrary percentages," says **Christina Metzler**, chief public affairs officer for the **American Occupational Therapy Association**. "Many amputees would rightly be placed in an IRF because of their health needs or their potential for rehabilitation."

"AOTA has always advocated that the '75 percent' rule, no matter what the actual percentage is, is a barrier to making individualized, appropriate care determinations," Metzler continues.

2. Expect More Specificity on Therapy Format

Next year, inpatient rehab facilities may need to document yet another item on their treatment plans and notes: whether the therapy is "individual," "group," or a "co-treatment."

What that means: The proposed IRF PPS rule spells out the definitions. Individual therapy is a one-on-one treatment, group therapy is one therapist per two to six patients, and co-treatment is one patient receiving treatment from two different therapists of differing disciplines (e.g. occupational therapy with speech therapy).

CMS also proposes a new section on the IRF-PAI that would record the number of therapy minutes per individual, group, and co-treatment over a 7-day period ... and for each therapy discipline.

"One thing AOTA is concerned about is assuring that the guidelines for various settings provide similar guidelines," Metzler comments. "Too many definitions across settings will cause confusion." For example, the skilled nursing facility setting has historically dealt with sorting out the appropriate use of group, concurrent, or co-therapy.

"It is our hope that the proposed changes do not impede a patient in the IRF access to group therapy and that the administrative burden for compliance is minimal," Drummond-Dye says.

Bottom line: The treating practitioner not arbitrary facility policy is what should dictate the therapy format, Metzler says. However, "AOTA supports CMS' previous guidance that the majority of therapy in an IRF should be individual and that, in general, other formats formats such as group should be adjunct to that individual therapy."

3. Watch for New Arthritis Item on the IRF-PAI

In addition to the therapy-format item CMS wants to add to the IRF-PAI, you may also see a new item for arthritis diagnoses that meet IRF requirements.

This "is an appropriate component of looking at the full patient picture to determine placement and plan of care," Metzler says. "Severe arthritis could be a significant factor in certain rehabilitation cases."

4. Expect 2 New Quality Reporting Outcomes Measures

Now that you've warmed up to the current CAUTI and pressure ulcer quality reporting measures, CMS wants to add two more: Staphylococcus aureus and Clostridium difficile. Noncompliance of these measures would result in payment adjustments for 2017. These may seem more like issues for nursing, but therapy can still play an important role.

Example: "Staph can decrease wound healing and impact pulmonary function. Physical therapists could provide care if the patient has increased lung secretions as a result of staph aureus," Drummond-Dye says. PT could also step in with wound care and debridement when indicated.

Likewise, occupational therapists can play a preventive role in either of these conditions. "As clinicians, we should be following standard precautions with all our patients, such as good hand hygiene," Metzler points out.

"Occupational therapists also have a role in early mobilization," she continues. "Studies have shown that early mobilization decreases length of stay, which would decrease possibility of getting an infection."

Think outside the box: Helping eliminate the need for invasive devices is also key, Metzler notes. For example, if a patient can transfer to a toilet independently, you could eliminate a catheter. Similarly, if therapy can help a patient improve activity tolerance and ability to breathe, you could eliminate a ventilator. "Avoiding these types of devices lessens the opportunity for infection and improves quality of care," Metzler says.