

Policy Change for Inpatient Rehabilitation Facility Length

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Introduction

Inpatient rehabilitation facilities (IRFs) provide rehabilitation care to patients after an injury, sickness, or surgery. Not every patient will require these services, but a significant number do utilize these services. Rehabilitation programs at IRFs include physical and occupational therapy, speech-language pathology, and prosthetic and orthotic devices. These facilities have to meet Medicare's requirements in order to be considered as an IRF. According to the Center for Medicare and Medicaid Services 2015 medpac.gov report, IRF care is provided in about 1,180 IRFs nationwide to over 340,000 Medicare beneficiaries. Also, Medicare accounts for about 60 percent of IRFs'.

Medicare pays IRFs through a per discharge prospective payment system (PPS). This has been the Medicare method of payment since 2002. Medicare also has specific criteria that a beneficiary must meet to determine whether or not their IRF services will be covered. IRF care requires a patient to be sufficiently stable at the time of admission to actively participate in the intensive rehabilitation program. Other patient criteria require active and on-going therapy in at least two modalities, one of which must be physical or occupational therapy. Also, the patient must actively participate in and benefit from intensive rehabilitation therapy that most typically consists of three hours of therapy a day at least five days a week.

The patient requires supervision by a rehabilitation physician. This requirement is satisfied by physician face-to-face visits with a patient at least three days a week. For a patient to qualify to receive care in an IRF, they must have had a minimum 3-day hospital stay. Medicare will help cover up to 150 days of stay in an IRF. If a patient leaves the facility or stops receiving care, their coverage will be impacted. Should the break last 30 days or more, the patient would need a new 3-day hospital stay to get additional care from an IRF.

Service Coverage Factors

Medicare Part A benefits are generally considered hospital insurance coverage. The inpatient rehabilitation facility (IRF) services are covered under Medicare Part A, as well as acute care hospitals, critical access hospitals and long-term care hospitals. The Medicare Part A coverage includes hospital services in a semi-private room, meals, nursing, medications required for the treatment provided during the hospital stay, supplies, and other hospital related services.

A physician must document medical necessity for treatment requiring two or more midnights of inpatient stay for the hospitalization to be Medicare reimbursable [1].

Under original Medicare, a patient will be responsible for a deductible (\$1,316) for each benefit period. If a patient has a stay from 1 to 60 days, then there's \$0 coinsurance for each benefit period. However, if a patient stays 61 to 90 days, then there is a coinsurance

(\$329) per day of each benefit period (CMS, 2017). After 91 days a Medicare beneficiary can use a lifetime reserve day up to 60 days at a higher coinsurance rate (\$658), but there are no coverage benefits if a patient goes over the 60-day lifetime reserve days.

Since 2002, the Medicare reimbursement system for intensive rehabilitation care changed from a fee for services to a prospective payment system [2]. This means that inpatient rehabilitation facilities (IRF) could have an underlying incentive to discharge patients earlier to reduce their length of stay (LOS) because the rate of reimbursement is set at a fixed rate based on the patient's case mix group (CMG) and the patient's comorbidity tier. There are 92 CMG groups and three comorbidity tiers [2]. The top three conditions include strokes with about 21% of IRF admissions, followed by lower extremity fracture with an approximate 16% admission rate and replacement of lower extremity conditions with about 13% [4].

The IRF payment system is based on a utilization average from the given CMG category and the patient's comorbidity tier combination. The payment system may create scenarios where patients with a shorter length of stay will represent a higher profit margin for the IRF. In an effort to mitigate undue influence for LOS manipulation, Medicare reimbursement rules pay a reduced rate if a patient is transferred out of the IRF prematurely based on customary category criteria. However, Medicare also provides for outlier adjustments if a patient has a greater than average LOS. IRF criteria require a pre-admission screening, a plan of care and a post admission evaluation. The plan of care must include the interventions detailing the expected intensity, frequency, and duration. The average intensive care plan will include 3 hours per day is about 6 days a week.

Informal Support Factors

In 2016 study researchers Lewis, Hay, Graham, Lin, Karmarkar, and Ottenbacher, determined that patients with social support had a greater probability of experiencing a shorter length of stay by at least one day. In contrast, patients who reported a lack of direct social support had a less likelihood of shorter lengths of stay. While their study only focused on three rehabilitation categories (stroke, lower extremity fracture and joint replacement), the findings illustrate how facilities are influenced to reduce the length of stay.

According to a 2014 longitudinal research study conducted by Bindawas et al. (4) lower extremity joint replacement is one of the most common impairment categories for Medicare patients who received inpatient rehabilitation care. They focused on a review of patient functional status post discharge from an IRF for patients with unilateral total hip replacement and patients with total knee replacement. The results from the report analysis (2014) indicated that when patients received an average of 2.7 hours therapy throughout their stay, patients continued to demonstrate improvement anywhere

from 3 to 6 months after discharge. The key appears to have inpatient treatment activities that concentrate on exercise and gait training. However, their study also revealed that post IRF discharge recovery from joint replacement often required additional rehabilitative care from either an outpatient setting and or in home rehabilitation.

Medicare Prospective Payment System (PPS)

Prospective payments systems (PPS) are gear to motivate and incentivize providers to deliver patient care without over consumption of services. The provider collects a flat amount or monthly premium and is responsible for providing services needed by the patient. The model promotes encouragement for providers to tailor management arrangements that produce diagnosis and treatment proficiently. With Medicare PPS systems, the provider collects a single payment for each patient. The payment amount is set to cover a particular period or the entire inpatient stay. In this process of allocating, the payment quantity established depends on diagnoses and standardized assessments. The provider-recipient of the payments is in charge for rendering whatever health care services are needed by the patient. The characteristics of PPS only apply to Part A inpatients. Also features of PPS include prepayment amounts for covered established periods of stay and disbursement amounts are determined on a distinctive valuation classification of each patient. Once, a patient exhausts the Part A benefit; the patient care cost may become Medicare Part B service coverage outside the qualifying PPS scope.

Assessment Tool

The mandated prospective payment system care assessment tool is the Functional Independence Measure (FIM) instrument. The 18-item FIM instrument is the most widely used medical rehabilitation tool that measures both motor and cognitive disablement. The FIM instrument commonly used for inpatient rehabilitation hospitals, skilled nursing facilities, and for treatment trials. The patient is evaluated and given a rate in levels of dependence. Patient independence is rated from 1 to 7, with seven translating to the highest functional rating. The periods for admission and discharge assessments are the first three days and then any one of the last three days of the hospitalization. The FIM instrument is used again at discharge and follow-up, with all modifications documented.

Medical rehabilitation facilities classify patients into payment groups on admission based on the FIM-FRG (Functional Improvement Measurement Function-Related Groups) system. Patients received one of the 85 Impairment Group Codes (IGCs) that falls into 1 of 21 diagnostic categories or Rehabilitation Impairment Categories (RICs). The objective is to group patients with similar use of resources and likely LOS. The case-mix groups designation and the comorbid conditions determine payment when the patient meets LOS and form of rehabilitation requirements. Patients have targeted goals for their ADLs (activities of daily living) depending on their primary diagnosis. According to CMS (2016), they want to see hospitals improving a patient's FIM score by 3.2 points for higher reimbursement rates on a value-based quality indicator. Some patients will not meet their goals before discharge. Patients with a SCI (spinal cord injury) may not be able to walk, but therapy can be provided to assist them with the wheelchair or any assistive devices.

However, shorter length of stay periods poses a challenge to the overall ability of therapy to improve the score. Luckily, the prospective pay system allows for more days to be allocated depending on the

medical contradictions of the patient. If a patient is deemed medically unable to improve FIM due to a lack of spasticity in muscles, respiratory distress, low white blood cell count, or any other reason (that falls within the criteria for extension) then the patient may lengthen their stay to accommodate for the missed opportunities to receive therapy. For a patient to get an extension on their LOS, the patient must meet the medical contraindications that qualify for the extension. Some situations create gaps. For instance, if a patient is suffering from a depressive episode due to an AKA (above the knee amputation), they may not be willing to participate in therapy, and this will affect their ability to recover with a high FIM score. Unfortunately, psychological episodes are not criteria's that allow for an extension to the LOS.

Recommendation for Policy Change

Several options can lead to service delivery improvements. The prospective payment method should be expanded to provide hospitals with in-depth guidelines for best practice length of stay (LOS) metrics that consider post-discharge factors. In addition to criteria for Inpatient Rehabilitation Facility coverage, the payment systems should require therapy training for informal caregivers. Policy improvements should incorporate additional rules, such a psychological delays, to qualify for an extension of LOS. This will benefit the patient to improve theirs ADLs before discharge and not be forced out the hospital before obtaining sufficient FIM score change. The goal is to allow more leverage on improving ADLs before discharge for a variety of patient circumstances and not only for medical contradictions. This will give the patient to self-heal physically and emotionally throughout the stay and raise the caliber of quality for the Inpatient Rehabilitation Facility.

IRF are there to help facilitate the process of the patient's capacity for being reintroduced into their communities as independently as possible. A lot of patients use IRF services when they have been in an accident or if they have gone through surgery in which they need rehabilitation services. The IRF allows each patient to heal at his or her own pace. There are a lot of benefits, and it's a tremendous aid in the times of need for each patient. IRF are also flexible in regards to the families being a part of the patient's rehabilitation process.

This social support is a significant influence on the determination of the patient's healing process and length of stay. "Inpatient rehabilitation experiences and outcomes can be substantially affected by a patient's level of social support [5]." If the patient does not see that they have the social support, they will surely not want to better themselves, and it will hinder the rehabilitation process. However, if the patient has a family support system to back them up, they will most likely need a smaller length of stay because they will be hoping to get well quick and get home to their loved ones. Therefore, with the patients that have left the IRF not fully recuperated, they cost a loss in profits due to their readmission. Each patient should go through an evaluation to verify if they are well enough to be discharged as opposed to risking the readmission rate. With the proper change in the policy set to play, we reduce the readmission rates and increase the probability for the patients to be completely healed before they are discharged.

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