

OIG REPORT ON INPATIENT REHABILITATION HOSPITALS SIGNALS THE POTENTIAL FOR INCREASED SCRUTINY

On December 23, 2016, the Department of Health and Human Services, Office of Inspector General ("OIG") released a report (the "Report") detailing a case review of inpatient rehabilitation ("rehab") hospitals.¹ The Report indicates that for 39 out of 426 rehab hospital stays reviewed, the patient was unable to participate in and benefit significantly from intensive therapy, which is a requirement for admission to an inpatient rehab hospital.

BACKGROUND ON INPATIENT REHAB HOSPITALS

Inpatient rehab hospitals are freestanding facilities that specialize in providing intensive rehab therapy to patients recovering from illness, injury or surgery and are designed to treat patients who can undergo intensive rehab therapy and benefit from it. Inpatient rehab hospitals are distinguished from other post-acute care settings by the intensity of the rehab therapy they offer. One main Medicare coverage criteria is that patients, at the time of admission, can be reasonably expected to "actively participate in, and benefit significantly from, an intensive rehabilitation therapy program."² Intensive rehab therapy requires a minimum of three hours of therapy per day, five days per week; a coordinated, interdisciplinary approach among multiple therapies, including physical therapy and occupational therapy; and rehab physician supervision. Medicare reimbursement for patients admitted to inpatient rehab hospitals can be higher than for other facilities in light of the level of therapy provided. For patients who require post-acute care but are unable to endure the rigors of inpatient rehab therapy, placement in another care setting, such as a skilled nursing facility ("SNF"), may be more appropriate.

FINDINGS

The Report indicates that for 39 of the 426 inpatient rehab hospital stays reviewed, the patients were not suited for intensive therapy and therefore likely not suited for treatment in an inpatient rehab hospital. The following four factors were cited by the government as limiting the patient's ability to participate in therapy.

- *Pre-existing physical limitations* - 30 of the 39 stays
- *Lack of endurance* - 27 of the 39 stays
- *Unresolved health problems* - 21 of the 39 stays
- *Altered mental status* - 18 of the 39 stays

The Report also indicates that for 32 of these 39 stays, the patients remained in the inpatient rehab hospital for an extended period of time, rather than being relocated to a more appropriate facility or setting.

PRACTICAL TAKEAWAYS

Although OIG's report did not contain any recommendations, OIG did conclude by encouraging the Centers for Medicare & Medicaid Services ("CMS") to consider providing additional technical assistance to ensure that Medicare patients are placed in the most appropriate setting for post-acute care and that inpatient rehab hospitals do not admit patients who are unable to participate in and benefit from intensive therapy.

In addition, OIG is currently performing a nationwide audit to determine whether hospital-based rehab units and freestanding inpatient rehab hospitals billing for inpatient rehab services are in compliance with Medicare documentation and coverage requirements and to examine how noncompliance affects Medicare costs. This audit, which is expected to be completed in 2017, will provide a national assessment of the proportion of inpatient rehab stays that do not comply with all Medicare coverage and documentation criteria and may prompt additional action from CMS.

This Report, coupled with previously published OIG reports focusing on inpatient rehab stays and the ongoing national review, signals the potential for increased scrutiny of inpatient rehab stays for both hospital-based rehab units and freestanding inpatient rehab hospitals. Furthermore, inpatient rehab hospitals were previously a major focus area of Recovery Audit Contractors ("RACs"), and in addition to the

medical necessity requirements discussed in the Report, such facilities also have highly technical documentation requirements for pre-admission screenings, post-admission evaluations, etc. With RAC activity expected to be renewed in the near future, providers should redouble their efforts to ensure compliance with all Medicare requirements for inpatient rehab stays.

If you have questions or would like additional information about this topic, please contact:

- Amy Garrigues at (919) 447-4962 or agarrigues@hallrender.com;
- Jon Zucker at (919) 447-4964 or jzucker@hallrender.com;
- Amy Poe at (919) 228-2404 or apoe@hallrender.com; or
- Your regular Hall Render attorney.

¹ *Case Review of Inpatient Rehabilitation Hospital Patients Not Suited for Intensive Therapy*, No. OEI-06-16-00360, 12-23-2016.

² 42 CFR § 412.622(a)(3)(ii); CMS, Medicare Benefit Policy Manual, ch. 1, § 110.2.

Please visit the Hall Render Blog at <http://blogs.hallrender.com> or click [here](#) to sign up to receive Hall Render alerts on topics related to health care law.