

Limiting Access to Inpatient Medical Rehabilitation

A Look at Payment Denials for Medicare Patients Treated in Inpatient Rehabilitation Facilities

EXECUTIVE SUMMARY

Inpatient rehabilitation hospitals and units provide hospital-level care for patients with medical and rehabilitation needs. These facilities treat patients with spinal cord injuries, major multiple trauma, hip fractures, strokes, brain injuries, severe burns, neurological disorders (i.e., multiple sclerosis, muscular dystrophy, Parkinson's disease) and knee and hip joint replacements. Modern medical advances also allow cancer, cardiac, transplant, pulmonary and pain patients, among others, to benefit from intensive rehabilitation care in inpatient rehabilitation facilities (IRFs). Care is coordinated by a multi-disciplinary team that includes specially trained rehabilitation physicians, registered nurses and therapists.

Since early 2005, IRFs around the country have seen a dramatic increase in cases where Medicare has denied payment for medical rehabilitation services. The majority of these payment denials are being successfully appealed; however, appeals require extensive staff time and resources and are very costly. The process for appealing denied claims can involve up to five tiers and is very lengthy. It takes an average of 18 months just to reach Level 3 (an administrative law judge hearing) and, during this time, the outcome is uncertain.

Uncertainty about whether they will be paid for care, coupled with the high administrative costs associated with increased payment denials and the lengthy appeals process, has led many IRFs to restrict the types of patients that they admit for care, reduce clinical and support staff and decrease the number of available beds. This reduces patient access to medical rehabilitation services, despite the fact that these patients need this level of specialized care to be able to return to everyday activities.

In an effort to highlight this emerging issue, a study on inpatient rehabilitation coverage policies and denied Medicare claims was undertaken from January through July 2007.



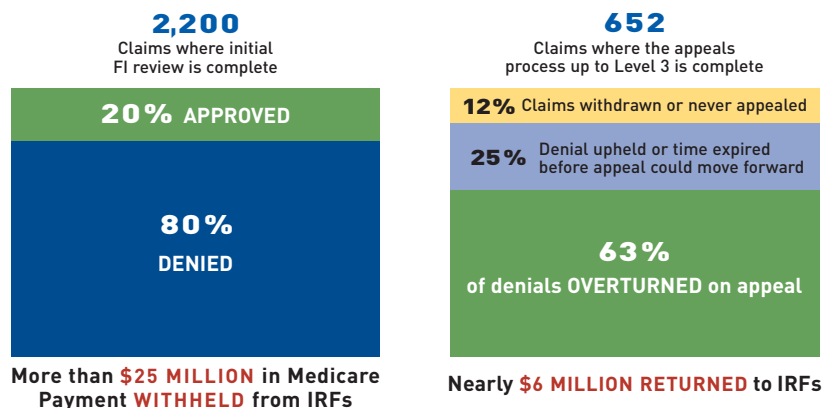
STUDY KEY FINDINGS

- Medicare beneficiaries are finding it more difficult to get needed inpatient rehabilitation services in the communities served by the inpatient rehabilitation facilities (IRFs) represented in this study.
- Fiscal intermediaries (FIs) contracted by the Centers for Medicare & Medicaid Services (CMS) are inappropriately denying payment for clinically necessary medical care, as demonstrated by the high number of overturned denials of Medicare claims.
- The lack of timely payment and the high administrative costs of appealing claims are creating unnecessary financial problems for IRFs.
- The Medicare Medical Necessity Guidelines (Section 110 of the *Medicare Benefits Policy Manual*) for inpatient rehabilitation services are being inconsistently interpreted and implemented.

Analysis of the sample claims from 72 IRFs found:

- Of the 72 facilities that submitted claims for analysis, 80 percent of claims for which the FI review was complete were denied payment.
- Of those claims that have completed the appeals process through the third level (an administrative law judge hearing), 63 percent of denials were overturned, returning nearly \$6 million to providers. FIs are inaccurately denying payment more than half of the time.
- Due to the lengthy appeals process over 1,000 claims, totaling over \$18 million in Medicare payment for patient care, are still being processed.
- The estimated cost to an IRF of appealing each claim is approximately \$2,000, resulting in an estimated cost to these facilities of over \$1.3 million.

Claims Data from 72 Inpatient Rehabilitation Facilities, July 2007



Many FIs are interpreting Medicare's national policy in more restrictive ways, creating inconsistencies in who does and does not receive inpatient rehabilitation care.

Despite the national Medicare guidelines in Section 110 of the *Medicare Benefits Policy Manual*, many fiscal intermediaries (FIs)—private companies that work for the Centers for Medicare & Medicaid Services (CMS) to pay Medicare claims submitted by providers—are applying more restrictive

interpretations of those guidelines and denying payments for medically appropriate inpatient rehabilitation care.

This restrictive interpretation plays out in two ways. The first is through the routine process of medical necessity review by the FI (as described in the sidebar on page 3). The second is occurring in areas of the country

where a particular FI has gone a step further and implemented a Local Coverage Determination (LCD) policy (as described in the sidebar on page 2). Of the 72 facilities that were part of this analysis, 58 (representing 87 percent of the claims analyzed) fell under the jurisdiction of an FI with an LCD in effect.

A comparison of Section 110 and several LCDs found that Medicare coverage is being limited by local FI activities. This comparison looked at LCDs by TriSpan, Mutual of Omaha, Blue Cross Blue Shield (BCBS) of Georgia, Cahaba GBA, and First Coast Service Options, as well as four of the five FIs that have consolidated under National Government Services (NGS) including AdminiStar Federal Inc., United Government Services (UGS), Associated Hospital Services and Anthem Health Plan of NH. A guidance memorandum from the TriSpan medical director also was reviewed as part of this analysis. Of the 12 FIs in this study, six have implemented LCDs. These six FIs review and process claims for approximately 31 percent of the 43 million Medicare beneficiaries across the nation.¹

National Medicare guidelines require physician review of each patient being considered for admission to an inpatient rehabilitation facility (IRF). This analysis found that these LCDs in general, and the TriSpan guidance memorandum in particular, introduce additional diagnosis-specific criteria for determining whether the patient is appropriate for admission to an IRF. The LCD further restricts national Medicare guidelines by narrowing the types of patients that they will approve for rehabilitation care.

For example:

- TriSpan states that the list of diagnoses/conditions included in its memorandum “should be considered to be a comprehensive list of indications such that clinical situations that are not specifically addressed should generally be considered inappropriate for inpatient rehabilitation.”²

CASE IN POINT: SSM REHAB, ST. LOUIS, MO

In May 2005, Mutual of Omaha issued a Local Coverage Determination (LCD) for inpatient rehabilitation services that narrowed the range of eligible patients. Rather than apply the LCD to all IRFs in its jurisdiction, it targeted a small number of providers, including SSM Rehab. SSM Rehab, a 100-bed facility, is a member of SSM Health Care and the largest provider of inpatient rehabilitation services in the St. Louis, MO, market. It also was the only provider in the region selected for a probe audit and forced to comply with the LCD.

Implementation of this LCD significantly restricted access for SSM Rehab patients. Out of frustration, referring surgeons began to send their patients to other hospitals for acute care and post-acute rehabilitation. As a result, SSM lost \$2.7 million, forcing the layoff of 100 doctors, nurses, therapists and support staff and the closure of two facilities.

As the impact of the LCD became clear, U.S. Senator Christopher Bond in a June 30, 2006 letter asked CMS to “end the selective enforcement of medical necessity until such time that this new definition can be uniformly and fairly applied.”

The end result of the LCD was that the local community suffered. Doctors, patients and families were forced to make tough choices and seek care in other facilities not limited by an LCD.

SSM Rehab's experience is a clear example of the detrimental effects of inconsistent medical necessity review of rehabilitation hospitals and units. Steve Johnson, the president of SSM Rehab at the time, described an angry call from the son of a former and prospective SSM Rehab patient. “He [the son] said, ‘You don't understand how important this is to my mother. I don't want to send her to a nursing home. I want her to come back to you,’” Johnson recalled. “I tried to explain [the LCD] to him as best as I could, and the only thing I could finally tell him was... ‘I don't want to [deny her admission] either, but I'm not allowed to [admit her] anymore.’”

Put simply, selective enforcement creates an uncertain, uneven regulatory and financial environment for health care providers, and a confusing medical environment for patients and clinicians.

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¹ The Henry J. Kaiser Family Foundation. “Total Number of Medicare Beneficiaries, 2005” www.statehealthfacts.org

² TriSpan Inpatient Rehabilitation Facility Services Final Local Coverage Determination. Effective date 08/14/05. TriSpan Guidance Document: How Medical Review will apply the LCD. Effective date 10/17/05.

Understanding **MEDICARE** Policy Coverage Determinations, Review and Appeals Processes

Medicare Policy and Local Coverage Determinations

CMS conducts medical necessity review of patient records to ensure that Medicare only pays for the care patients need. Medical necessity review is based on clinical criteria and other guidelines outlined in Section 110 of the *Medicare Benefits Policy Manual*. The Section 110 guidelines are based on a CMS ruling known as “HCFA Ruling 85-2.” CMS contracts with fiscal intermediaries (FIs) (private companies that work for CMS to pay Medicare claims submitted by providers) to conduct medical necessity reviews of inpatient rehabilitation facilities (IRFs), which involves the review of Medicare claims and patient medical records.

Providers and regulators rely on Section 110 and HCFA (now CMS) Ruling 85-2 to help them determine which patients are appropriate for hospital-level, medical rehabilitation. In addition, these criteria help distinguish the hospital-level care provided in inpatient rehabilitation hospitals and units from care in less-intensive settings, such as nursing homes. Because the criteria are not based on particular conditions, these guidelines provide a flexible framework that accommodates advances in medical science and technology.

HCFA (now CMS) Ruling 85-2/Section 110 Criteria for Medicare Coverage of Inpatient Rehabilitation

Inpatient rehabilitation patients must have a condition that requires medical rehabilitation at a hospital level. This is established through the following criteria:

- Require intensive rehabilitation (generally at least three hours per day);
- Require care by a physician with rehabilitation training or experience;
- Require 24-hour care by a registered nurse with rehabilitation training or experience;
- Require a coordinated care program delivered by a multidisciplinary team that includes at least a physician, rehabilitation nurse and therapists, and also often includes social workers and/or a psychologist;
- Be expected to achieve significant improvement in a reasonable period of time;
- Have realistic rehabilitation goals that focus on achieving the maximum level of independent function; and
- Have a reasonable length of stay.

Certain FIs have established Local Coverage Determination (LCD) policies³ to clarify Medicare coverage guidelines for providers in their jurisdictions. Per CMS’ guidelines, LCDs may not restrict national coverage as outlined in Section 110 of the *Medicare Benefits Policy Manual*. Rather, their purpose is to clarify the clinical criteria and circumstances that are considered to be reasonable and necessary for Medicare coverage.

Review Process

CMS’ FIs perform data analysis and claims review to assess whether Medicare coverage guidelines are being met. First, a “widespread pre-payment review” of specific diagnosis codes used on the claims can be implemented within a region when the contractor’s data analysis notes problems with documentation supporting medical necessity. This involves the contractor reviewing approximately 100 claims from multiple facilities or 20-40 claims per provider to assess whether providers are complying with Medicare guidelines. The contractor notifies providers in the region of a widespread “pre-payment probe review”⁴ and the dates when the review will be conducted. Medical review determines whether provider education is needed.

An FI also may implement pre-payment or post-payment claim reviews on a provider level. Under pre-payment review, the contractor reviews a sample of a hospital’s claims against medical necessity guidelines BEFORE they are paid to determine the percentage of cases that comply with Medicare guidelines. Under pre-payment review, an FI can deny payment for claims it deems inconsistent with medical necessity standards. To be removed from pre-payment review, a provider must exceed a certain threshold of compliant cases, as determined by the FI. Post-payment review is conducted on claims that have already been paid by Medicare and can lead to providers having to return payments to Medicare for claims determined to lack adequate medical necessity.

As part of a medical review audit, the contractor can solicit additional documentation from the provider by issuing an Additional Documentation Request. Providers must respond to any requests for additional documentation from the contractor within 60 days.

The Appeal Process ►

³ Section 522 of the Benefits Improvement and Protection Act (BIPA) created the term “local coverage determination (LCD). An LCD is a decision whether to cover a particular service on an intermediary-wide or carrier-wide basis (in accordance with Section 1862 (a)(1)(A) of the Social Security Act). (CMS website, July 2007)

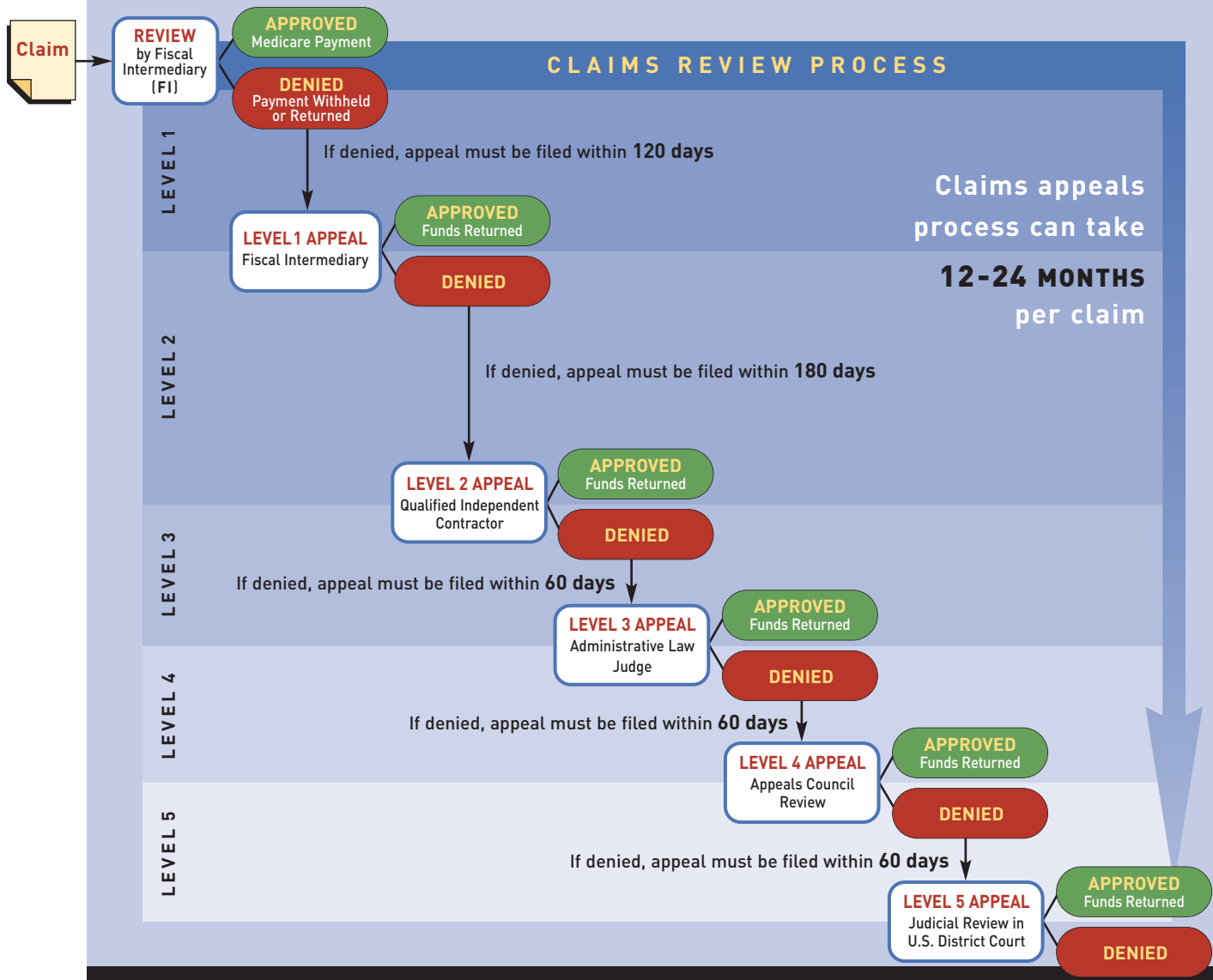
⁴ Providers with identified problems submitting correct claims may be placed on “pre-payment review”, in which a percentage of their claims are subjected to review before payment can be authorized. Once providers have re-established the practice of billing correctly, they are removed from pre-payment review. (CMS Factsheet, September 2004)

Claims Appeal Process

IRFs have the right to appeal claim denials through a five-step Medicare claims appeal process. A different organization reviews appeals at each step of the process, as noted below.

LEVEL OF APPEAL	REVIEWING BODY
Level 1	Fiscal Intermediary Redetermination
Level 2	Qualified Independent Contractor (QIC) Reconsideration
Level 3	Administrative Law Judge (ALJ) Hearing
Level 4	Medicare Appeals Council Review (Appeals Council)
Level 5	Judicial Review in U.S. District Court

Responding to initial requests and appealing claim denials is a time-consuming process. For each claim, an IRF must compile extensive documentation from clinical and administrative staff. Several facilities that participated in this study stated that the initial preparation time for each claim is, at minimum, eight hours, while the typical response time for those requests is within 30 days. In addition, IRFs dedicate significant resources, including some travel costs for the hearings associated with each appeal level. Each level of appeal has specific filing deadlines ranging from 60-180 days, as noted below. A typical appeal requires approximately 18 months from initial filing through an administrative law judge hearing (Level 3). If a provider is dissatisfied with the ALJ decision, review by the Appeals Council can be requested. Judicial review before a U.S. District Court is the highest level of appeal.



- Similarly, the Mutual of Omaha LCD states: "Consider that an inpatient hospital stay for rehabilitation care is not covered for these select conditions because meeting all the criteria for medical necessity would be unlikely."⁵

Excessive medical necessity review, with or without an LCD, causes confusion among providers and inconsistencies in access to care around the country and even within specific communities. LCDs are causing unique challenges for referring surgeons, IRF providers and patients in communities where multiple LCDs are in effect. In this scenario, patients are being denied admission at one IRF, only to be admitted by another IRF that is under a less restrictive LCD or no LCD at all.

The reasons for denials vary across FIs and from facility to facility. However, some FIs consistently are denying payment for patients with conditions that qualify under the "75% Rule," such as stroke, brain injury, spinal cord injury and hip fracture. The 75% Rule established facility criterion that IRFs must meet to participate in the Medicare program and requires that a certain percentage of patients within each facility fall within 13 qualifying conditions. Denial of payment of patients with approved 75% Rule conditions is particularly concerning because research by RAND⁶ has validated

these conditions as being typically appropriate for the IRF setting. The narrower medical necessity interpretation being implemented by numerous FIs and the 75% Rule qualifying conditions creates great difficulties for facilities trying to manage within CMS regulation.

The FI role is clear: They have guidelines for medical necessity review. The FIs have a responsibility to providers to educate them about why claims have been denied so that IRFs can respond appropriately. With few exceptions, FIs have been unresponsive to requests for clarification. When they have responded, FI feedback has been non-specific, with little to no clarification. For example, some denial letters give no specific reasons for denials and simply state that the case "does not meet medical necessity." In addition:

- In order for many facilities to be removed from pre-payment review, their denial rate must drop below a certain threshold set by the FI. For some facilities, the denial rates being calculated by the FI are consistently incorrect due to their inability to keep track of the claims they are reviewing. This type of avoidable error prolongs the pre-payment review process.
- One FI is consistently denying claims based on outdated IRF prospective

payment information, causing preventable errors and delays that result in additional burden for providers.

- One facility reported working with an FI to come to agreement on a corrective action plan to be implemented by the facility. However, that corrective action plan, once agreed to by the FI, was not systematically shared with other facilities under the FI's jurisdiction, resulting in many more facilities remaining on post-payment review.
- Finally, one facility that had implemented electronic nursing records was consistently having claims denied because its FI would not accept the abbreviations that the system exported into the medical record. The FI would cite "inappropriate documentation" in the record and deny the claim. That facility has now had to discontinue using its electronic nursing record for IRF patients.

The above examples reflect the inability of many FIs to appropriately conduct medical necessity reviews in IRFs. FI reviewers may lack the clinical experience necessary to make accurate and appropriate determinations. As a result, a high rate of denied claims are later being overturned at great cost to IRFs and their patients.

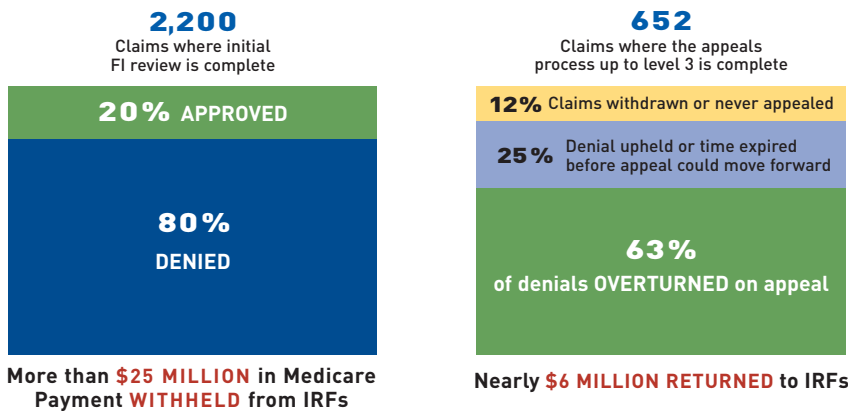
63 percent of Medicare payment denials are being overturned upon appeal

Since early 2005, IRFs have been targeted with excessive medical necessity review. In many cases, the majority of the claims that come under review are paid, but claims continue to be denied at an increasing rate. The most aggressive denials are taking place in areas of the country where an FI has implemented an LCD. The typical appeals process takes 12-24 months and, during this time, facilities are expending valuable resources to appeal these claims.

Data was collected from 72 inpatient rehabilitation facilities in 20 states from

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Claims Data from 72 Inpatient Rehabilitation Facilities, July 2007



Note: For a more detailed depiction of the data collected, please see Appendix on page 8.

⁵ Mutual of Omaha Local Coverage Determination for Inpatient Rehabilitation Services. Revised 09/28/06.

⁶ Grace M. Carter, Melinda Beeuwkes Buntin, Orla Hayden, Susan M. Paddock, Daniel A. Relles, Greg Ridgeway, Mark E. Totten, Barbara O. Wynn, Analyses for the Initial Implementation of the Inpatient Rehabilitation Facility Prospective Payment System-2002, RAND, http://www.rand.org/pubs/monograph_reports/MR1500/.

January through July 2007. The facilities that participated in this data collection are currently under the jurisdiction of 12 different FIs including Arkansas BCBS (Pinnacle Business Solutions, Inc.); BCBS of Georgia; Cahaba Government Benefit Administrators LLC; COSVI; First Coast Service Options, Inc.; Highmark Medicare Services (formerly Veritus Medicare Services); Mutual of Omaha; NGS (a consolidation of five FIs); Palmetto GBA; Riverbend; TriSpan Health Services; and UGS (now part of NGS).

Analysis of sample claims from the 72 IRF facilities found:

- Of the 72 facilities that submitted claims for analysis, 80 percent of claims for which the FI review was complete (1,763 claims) were denied payment.
- Ninety-six percent of those denied claims are being appealed by IRFs.

- Of those that have completed up to Level 3 of the appeals process—an administrative law judge hearing (ALJ)—63 percent of denials were overturned, returning nearly \$6 million to the facilities.

For example:

- An IRF in Louisiana experienced a 70 percent denial rate for Medicare claims. Upon appeal, approximately 73 percent of the denials were overturned. The overturned denials totaled \$807,158 in Medicare payment for patients that received medically necessary care.
- An IRF in Mississippi experienced a 61 percent denial rate of Medicare claims. Upon appeal, approximately 55 percent of those claims have been overturned, with three more claims still pending review. The overturned denials totaled \$603,495 in Medicare payment for

patients that received medically necessary care.

Several ALJ decisions, the third and frequently final stage of the appeals process for many facilities, held that the care provided by the facilities did satisfy Medicare's medical necessity criteria. Although it is difficult to draw conclusions due to the case-specific nature of the decisions, ALJs base their decisions on the medical records and testimony, and issue decisions on whether the care was necessary in the IRF setting. For the denials overturned upon appeal, the facility was able to present evidence of the medical necessity of care, the same evidence that was submitted to the FI in previous appeal steps.

Inappropriate medical necessity denials divert resources from patient care

Successful appeals are returning a significant portion of denied Medicare payments back to IRFs. While this helps IRFs and their patients, the time and costs associated with the appeals process is excessive, avoidable and diverts resources from patient care.

Many smaller, independent facilities without the support of a larger health care system are on the brink of closure because they are not receiving timely payment for services, creating a disruption in cash flow during the 12-24 month appeals process. Such providers have significantly decreased the number of beds and resources available to patients.

The burden is not only financial. In order to effectively appeal the claims, a large amount of clinical and administrative staff time must be diverted to provide additional documentation to the medical record by reinterviewing the physicians and other medical staff involved in the case. In some instances, the order of information in the medical record has been the reason for

Total claims that have completed the appeals process		Estimated cost to appeal each denied claim		Estimated cost to providers to appeal claims
652	X	\$2,000	=	\$1.3 MILLION

denial. As a result, the documentation must be reordered and recopied to appeal the claim, diverting staff time away from patient care. In addition, many facilities hire, at a significant cost, outside consultants and legal counsel to help them in the appeals process.

Many facilities have documented the estimated cost of appealing their claims. Below is a snapshot of these costs.

- Depending on the size and ability of the facility, many estimated it costs approximately \$2,000 to see a claim through just the first three levels of the appeals process.
- The estimated cost to an IRF of appealing each claim is approximately \$2,000—resulting in an estimated cost to these facilities of over \$1.3 million.
- An IRF in Louisiana noted that in the two years it took to recoup \$800,000 through the claims appeal process, the effort cost \$230,000 for legal fees, staff hours, postage and copies.
- The total administrative costs associated with appealing 59 claims were estimated to be over \$140,000 (on average over \$2,300 per claim) by one facility and took over two years to complete.
- Another IRF spent nearly \$200,000 in attorney costs, staff time, copies and postage, travel to and from the FI, and consultant fees in appealing 70 denied claims. That is nearly \$3,000 per claim in administrative costs.
- Several facilities have had to create departments of up to five people solely to handle claim denials and appeals.

Excessive probe reviews and payment denials are threatening the ability of IRFs to provide patients with access to medically necessary care

In response to excessive medical necessity review by the FIs, facilities are finding themselves at a crossroads: Providers face the tough decision of whether and how to determine who will and will not receive care.

Since the final outcome of an appeal is often unknown and 12-24 months away, **many providers must immediately limit or restrict admissions for patients the FI has indicated it will not approve for payment, even when the referring physician has determined the patient meets the criteria for inpatient rehabilitation care.** This choice limits access to care

RECOVERY AUDIT CONTRACTORS

In March 2005, CMS implemented the Recovery Audit Contractor (RAC) demonstration program to ensure correct payments to providers. This demonstration was made permanent in the Tax Relief and Health Care Act of 2006 and uses RACs to search for additional improper Medicare payments to Medicare providers that were not detected through existing program integrity efforts. The RACs currently operate in California, Florida and New York and, as of September 2007, will expand to Arizona, Massachusetts and South Carolina. The program is expected to roll out to all 50 states by 2010.

Just like FI medical necessity review, the RAC demonstration program is producing high rates of denied Medicare payments. In California, large amounts of Medicare payment are being recouped for care provided in inpatient rehabilitation hospitals through this process. An investigation of these denials by the Office of the Inspector General has been requested.

CASE IN POINT: MADONNA REHABILITATION HOSPITAL, LINCOLN, NE

When Fred Daigle suffered a stroke, his family was not thinking about Medicare criteria or guidelines used by a medical reviewer that could have affected his care. Seventy-one-year-old Daigle arrived at Madonna Rehabilitation Hospital in Lincoln, NE, with left arm and leg weakness, blurred vision and vision loss, poor balance with risk of falling, impaired mobility and slurred speech, as well as a host of medical problems related to his recent stroke. Medicare identifies these symptoms as qualifications for rehabilitation care, and the Daigle family assumed Medicare would pay for the cost. But when Daigle's claim was submitted to Mutual of Omaha, which performs medical reviews in 49 states including Nebraska, payment was denied on the opinion that his level of rehabilitation care was not "medically necessary."

But don't tell that to Fred Daigle. "I went into Madonna in a wheelchair and after 10 days, I was able to walk out on my own," he said. "My therapist had me sweeping leaves with a rake in one hand and my cane in the other. It helped me get back to doing everyday things."

When Daigle's claim was denied, Madonna Rehabilitation Hospital had to reimburse Medicare for the cost of his care. Madonna subsequently appealed the denial and won.

"I don't know what would have happened to me if I couldn't have gone to Madonna," said Daigle. "I'm back to shoveling snow for my elderly neighbors and picking up my grandkids after school. That's what matters to me."



for patients and creates tensions between IRF providers and referring physicians.

In recent months, an IRF in Florida faced this very decision, as did another in Georgia, due to their initial medical necessity review denials. Today, as a result, **both facilities are reluctantly denying admission to patients who do not qualify under their FI's narrower interpretation of the medical necessity criteria in order to avoid further payment denials and the subsequently lengthy, costly and uncertain appeals process.**

One facility now conducts pre-admission evaluations and refuses admission to patients who referring physicians have deemed clinically appropriate for IRF care but have diagnoses and case histories similar to those of prior patients for whom the local Medicare contractor has denied claims. In response to increased denials, another IRF reduced admissions, laid off 50 percent of its staff and decreased the number of beds by almost 70 percent.

CONCLUSIONS

The issue of excessive and inconsistent medical necessity review, compounded by the implementation of LCDs, is one that many IRFs are just now experiencing, whereas others have been dealing with such problems since early 2005. At the core of this issue: the impact on patients and the community.

Decisions regarding whether Medicare patients needing inpatient rehabilitation care should or should not be admitted to IRFs is being decided by an FI, rather than the clinical judgment of the referring surgeon and admitting physician. This inconsistent interpretation of Medicare coverage policy creates inequities in patient access to care.

This issue is at a boiling point, as many facilities are on the brink of making difficult decisions about whether to continue providing inpatient rehabilitation care in their communities. The administrative costs alone of appealing claims that are then overturned more than 60 percent of the time imposes a burden on IRFs and results in greater costs to the entire health care system.



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POLICY QUESTIONS

- Who should have the final say in interpretation of medical necessity?
- Is CMS providing adequate oversight of FIs conducting medical necessity review?
- Do FIs have appropriate inpatient rehabilitation physician involvement in claims review?
- Should FIs be penalized for a high percentage of overturned appeals?
- How should CMS reconcile the inconsistency between certain patients being identified as appropriate for inpatient rehabilitation care under the 75% Rule while some FIs deem them to be “unlikely” or “inappropriate” candidates for this setting?

APPENDIX

TABLE 1:

Total Claims Collected for REVIEW: 2,886⁷	Total Claims DENIED as of July 2007: 1,763	Of those claims that have completed FI review, 80% have been DENIED PAYMENT	Nearly \$25 MILLION in Medicare payment has been WITHHELD from IRF facilities
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TABLE 2: Summary of IRF Claims Analysis, July 2007

	NUMBER OF CLAIMS	PERCENTAGE	TOTAL DOLLARS ⁸
Initial FI Review Complete	2,200	76%	
Total Approved	437	20%	
Total Denied	1,763⁹	80%	Nearly \$25 million
Total Still Undetermined	563	26%	Nearly \$7 million
Total Denied	1763¹⁰		Nearly \$25 million
Total claims that have completed the appeals process up to the ALJ level or earlier ¹¹	652	37%	Nearly \$8 million
Claims with completed appeals that have been overturned	414	To date, 63% (414/652) have been overturned on appeal	Nearly \$6 million returned to IRF providers
Claims still under appeal	1,028	58%	Over \$18 million
Denial upheld or time expired for appeal to move forward ¹²	161	9%	Nearly \$2 million

⁷ Due to the lengthy appeals process (on average 12-24 months) claims data is from 2005, 2006 and early 2007. In addition, 123 out of the 2,886 claims, the status is unknown, however, we anticipate that they were still pending FI review but were unable to verify that information.

⁸ Of the 1,763 claims denied, there are approximately 108 claims for which we did not have dollar amounts and therefore these amounts are underestimated.

⁹ The total number of claims denied (1,763) includes 83 claims for which the status is unknown.

¹⁰ Ibid.

¹¹ A total of 77 denied claims were either never appealed or withdrawn from the appeal process by the provider.

¹² A total of 161 claims began the appeals process and discontinued the appeals process or were not further appealed due to lack of documentation or unavailability of resources to appeal the claim. In addition, in some cases, the time had run out for the appeal to continue.