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Case Review of Inpatient Rehabilitation Hospital Patients Not Suited for Intensive Therapy

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Case Review of Inpatient Rehabilitation Hospital Patients Not Suited for Intensive Therapy

Key Points

- Patients who were not suited for intensive rehab therapy **had physical limitations and lacked endurance**.
- Inpatient rehab hospitals **kept some patients** who were unsuited for intensive therapy **for extended periods of time**.
- Some of the patients who were unsuited for intensive therapy were in **very poor condition** and died within weeks of being admitted to inpatient rehab hospitals.

Why We Did This Review

Inpatient rehabilitation (rehab) hospitals are freestanding facilities that specialize in providing intensive rehab therapy to patients recovering from illness, injury, or surgery. This intensive therapy requires endurance that some patients receiving post-acute care do not have, potentially causing those patients to be better suited for an alternate setting such as a skilled nursing facility. Medicare criteria for admission to post-acute care help ensure that patients receive the most appropriate care for their conditions and needs. In conducting a medical review for a separate evaluation to identify adverse events in inpatient rehab hospitals, physician reviewers found a small number of hospital stays in which the patients appeared to be unsuited for intensive therapy. In response, we extended our medical review to provide additional information about these stays in which patients were unable to actively participate in and benefit significantly from intensive therapy.

How We Did This Review

We contracted with physicians to review medical records for a sample of patients admitted to inpatient rehab hospitals during March 2012. The physicians identified 39 inpatient rehab hospital stays in which patients were unable to actively participate in and benefit significantly from intensive therapy. For these stays, the physician reviewers identified factors that contributed to the patients' inability to participate and benefit. We also analyzed claims data to determine whether inpatient rehab hospitals kept these unsuitable patients for extended periods of time.

What We Conclude

Most patients (32 of 39 stays) who physician reviewers determined were not suited for intensive rehab therapy remained in inpatient rehab hospitals for extended periods of time, including some who were in very poor condition. We encourage the Centers for Medicare & Medicaid Services 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. An Office of Inspector General audit that is currently in progress will provide a national assessment of the proportion of inpatient rehab stays that do not comply with all Medicare coverage and documentation criteria.

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BACKGROUND

Objective

To examine inpatient rehabilitation (rehab) hospital stays for patients who were unable to participate in and benefit from the intensive rehab therapy provided.

Providers of Post-Acute Care

Providers of post-acute care offer recuperation and rehab services to Medicare beneficiaries, typically after stays in acute-care hospitals. These providers include skilled nursing facilities (SNFs), home health agencies, long-term care hospitals, hospital-based rehab units (i.e., rehab units that are part of acute-care or critical access hospitals), and freestanding inpatient rehab hospitals (i.e., rehab facilities that are not managed as units within other hospitals). In fiscal year (FY) 2012, many more SNFs than inpatient rehab hospitals billed Medicare for post-acute care (14,938 SNFs, versus 234 inpatient rehab hospitals). SNF patients are typically older, frailer, and more likely to report poor health status and to be disabled than patients in other post-acute settings.¹ In contrast, inpatient rehab hospitals treat patients who can tolerate intensive rehab therapy and gain from it.²

The different types of post-acute-care providers often treat patients with similar conditions; Medicare pays different amounts depending on the setting. For example, Medicare pays 40 to 50 percent more for patients recovering from strokes and hip replacements in hospital-based rehab units and inpatient rehab hospitals than it does for those in SNFs.³ In FY 2012, SNFs received an average reimbursement of \$12,000 per admission, compared to \$17,000 for inpatient rehab hospitals.^{4, 5}

Inpatient Rehabilitation Hospitals

Inpatient rehab hospitals are freestanding facilities that specialize in providing intensive rehab therapy to patients recovering from illness, injury, or surgery. In contrast, hospital-based rehab units provide the same type of care as inpatient rehab hospitals and are reimbursed through the same prospective payment system, but are located within a larger hospital—an acute-care hospital or critical access hospital—and are managed as part of that hospital. In FY 2012, hospital-based rehab units constituted approximately 80 percent of the market for intensive inpatient rehab therapy; inpatient rehab hospitals—the focus of this study—constituted the remaining 20 percent.⁶

Admission to Inpatient Rehabilitation Hospitals

The criteria for Medicare coverage of post-acute care help ensure that patients receive the most appropriate level of care for their needs.⁷ The primary distinction between inpatient rehab hospitals and other settings for post-acute care is the intensity of the rehab therapy provided.⁸ One requirement of the 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.”⁹ Intensive therapy differs from the therapy provided in other settings for post-acute care in that it generally requires substantial time (at least 3 hours of therapy per day, 5 days per week); a coordinated, interdisciplinary approach among multiple therapies (e.g., physical therapy, occupational therapy); and rehab physician supervision.¹⁰ This intensive therapy is beyond the endurance level of some patients receiving post-acute care, potentially causing them to be better candidates for an alternate setting such as

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SNFs. Centers for Medicare & Medicaid Services (CMS) policy stipulates that intensive therapy must never exceed the post-acute patient's level of need or tolerance, or compromise the patient's safety.¹¹

To be eligible for Medicare payment for a beneficiary's stay, inpatient rehab hospitals must complete a preadmission screening and post-admission evaluation to document that the patient meets the Medicare coverage criteria (listed above) and must include this documentation in the patient's medical record.¹²

To assess whether a patient is a suitable candidate for an inpatient rehab hospital, rehab clinicians conduct a preadmission screening to evaluate the patient's condition and need for rehab therapy.¹³ Then, within the first 24 hours after the patient's admission, a rehab physician conducts a post-admission evaluation of the patient. This post-admission evaluation includes an assessment of the preadmission screening and of the patient's current status, and it is used by the rehab physician to develop the patient's expected course of treatment.¹⁴

In rare cases, a patient's preadmission screening could indicate that the patient is a suitable candidate for the inpatient rehab hospital but the post-admission evaluation could find that the patient is not able to participate in or benefit from intensive therapy. In these cases, Medicare requires that the inpatient rehab hospital immediately begin the process of discharging the patient. Because another setting for post-acute care may not be immediately available, Medicare allows the inpatient rehab hospital to continue treating the patient until the hospital finds another setting. In these cases, Medicare will pay claims submitted by inpatient rehab hospitals for the first 3 days of the patient's stay.¹⁵

Office of Inspector General Work Related to Inpatient Rehab Hospital Requirements

In February 2013, the Office of Inspector General (OIG) published a report that reviewed claims for one hospital-based rehab unit to determine compliance with the 2010 Medicare documentation requirements for inpatient rehab services.¹⁶ OIG found that for 98 of the 100 claims reviewed, this hospital-based rehab unit did not comply with Medicare documentation requirements. OIG found that for these 98 claims, the rehab unit improperly received a total of more than \$2.7 million in Medicare payments. OIG recommended that the hospital develop and implement procedures to ensure that it bills Medicare only for inpatient rehab services that comply with Medicare documentation requirements.

In 2016, OIG published a series of reports that determined whether three individual hospitals complied with Medicare requirements for billing inpatient and outpatient services, including inpatient rehab services.¹⁷ OIG found that each of the three hospitals submitted claims for inpatient rehab services that did not meet Medicare criteria and that they improperly received payments for these claims. OIG recommended that each hospital strengthen controls to ensure full compliance with Medicare requirements.

The findings from the 2013 and 2016 reports prompted OIG to conduct a nationwide audit to determine whether hospital-based rehab units and freestanding inpatient rehab hospitals billed for inpatient rehab services in compliance with Medicare documentation and coverage requirements, and to examine how noncompliance affects Medicare costs. This audit is currently in progress; OIG anticipates completing it in 2017.

BACKGROUND

Methodology

We conducted this assessment following a study of adverse events in inpatient rehab hospitals, titled *Adverse Events in Rehabilitation Hospitals: National Incidence Among Medicare Beneficiaries* (OEI-06-14-00110).¹⁸ In reviewing the medical records for 426 stays to identify adverse events, physician reviewers found a small number of cases in which the patients appeared unable to participate in and benefit from intensive therapy. In response, we extended our medical record review to provide additional information about inpatient rehab hospital stays in which patients were unable to actively participate in and benefit significantly from intensive therapy.

We contracted with three physician reviewers—a geriatrician, a physiatrist, and a physiatrist who is also a neurologist—to review the medical records for the patients in such stays.¹⁹ Physician reviewers had access to complete medical records for the sampled beneficiaries' stays in inpatient rehab hospitals, including preadmission screening information, post-admission evaluations, and notes from scheduled therapy. Physician reviewers paid particular attention to therapy notes recorded during the first 3 days of each inpatient rehab hospital stay.

Physician reviewers identified 39 inpatient rehab hospital stays in which patients were unable to actively participate in and benefit significantly from intensive therapy. For these stays, we describe factors that our physician reviewers identified as having contributed to the patients' inability to fully participate in intensive rehab therapy. We also analyzed claims data to determine whether inpatient rehab hospitals kept these patients for extended periods of time, which we defined as a stay lasting longer than 3 days.

Limitations

Our findings are limited to beneficiaries who were discharged from acute-care hospitals and admitted to inpatient rehab hospitals during March 2012. The findings may not be reflective of a different month.

We did not assess whether patients in our sample met all Medicare coverage criteria for admission to inpatient rehab hospitals or whether the medical records for the patients in our sample contained the proper documentation to support admission to an inpatient rehab hospital. Additionally, we did not assess the cost implications to Medicare of patients who were placed in inpatient rehab hospitals but were not suited for intensive rehab therapy. These considerations will be addressed in OIG's nationwide audit that is currently in progress.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Patients who were not suited for intensive rehab therapy had physical limitations and lacked endurance

Physicians identified 39 inpatient rehab hospital stays involving patients who were not suited for intensive therapy. For the 39 stays, physician reviewers identified factors affecting the patients' ability to participate in and/or benefit from therapy. The factors affecting the most patients were pre-existing physical limitations and lack of endurance. Overall, these factors fell into four categories (and physicians often cited more than one factor for each patient):

- *Pre-existing physical limitations*—For 30 of the 39 stays, physical limitations restricted the patients' ability to participate in therapy. These physical limitations included pre-existing functional disabilities, limited mobility, and inability to carry out activities of daily living (e.g., getting in and out of bed; dressing; bathing; eating; and using the bathroom). Patients with physical limitations had comorbidities such as cerebral palsy, degenerative joint disease, and morbid obesity.
- *Lack of endurance*—For 27 of the 39 stays, inadequate physical endurance limited the patients' ability to participate in intensive therapy. For example, one patient was severely compromised by muscle weakness and malnutrition at admission.
- *Unresolved health problems*—For 21 of the 39 stays, unresolved health problems limited the patients' ability to participate in therapy. Medical records for these patients described problems such as inadequate recovery from a prior illness or surgery; uncontrolled pain; debilitation from cancer; and pressure ulcers. For example, one patient had not adequately recovered from numerous cardiac issues (including arrhythmia, mitral insufficiency, and congestive heart failure) to fully participate in therapy at the time of admission to an inpatient rehab hospital. In another instance, a patient had uncontrolled pain from a chronic pain disorder (reflex sympathetic dystrophy syndrome), compounded by experimental chemotherapy to treat metastatic colon cancer.
- *Altered mental status*—For 18 of the 39 stays, altered mental status limited the patients' ability to participate in therapy. Medical records for the patients in this category described cognitive problems such as delirium and dementia. For example, one patient was difficult to rouse and unable to remain alert during therapy due to significant delirium. Another patient had severe dementia and was unable to follow commands during therapy.

Inpatient rehab hospitals kept some patients who were unsuited for intensive therapy for extended periods of time

Physician reviewers determined that for 32 of the 39 stays in which they deemed patients to be unsuited for intensive therapy, the patients remained in the inpatient rehab hospitals for extended periods of time (which we defined as stays lasting longer than 3 days) despite being unable to participate in and benefit

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from the intensive therapy. The average length of stay in the inpatient rehab hospitals for these 32 patients was 15 days, with a range from 5 days to 24 days.

Some of the patients who were unsuited for intensive therapy were in very poor condition and died within weeks of being admitted to inpatient rehab hospitals

For 7 of the 39 stays in which patients were unable to actively participate in and benefit from intensive therapy, the medical records indicated that the patients were in exceptionally poor condition and died within a few weeks after being admitted to an inpatient rehab hospital. In all seven cases, patients were unable to participate in therapy and were kept in inpatient rehab hospitals for longer than 3 days. One of the patients was recovering from a stroke and had multiple comorbidities, including complications of paralysis of one side of the body, pneumonia, and a Stage II pressure ulcer. Upon arrival at the inpatient rehab hospital, the patient was too lethargic to provide a history and was unable to follow commands. Despite being unable to participate in therapy, the patient spent 11 days at the inpatient rehab hospital before being discharged to hospice, dying there 8 days later. In another case, a patient was admitted to an inpatient rehab hospital while undergoing palliative chemotherapy for advanced metastatic cancer. The patient was significantly fatigued and sedated from narcotics given for pain. The patient was discharged after 13 days in the inpatient rehab hospital and died 4 days later.

CONCLUSION

In examining the medical records of Medicare patients admitted to freestanding inpatient rehab hospitals, physician reviewers found 39 patients who were unsuited for intensive therapy because of physical limitations and lack of endurance. Most of these patients remained in inpatient rehab hospitals for extended periods of time, including some who were in very poor condition. We encourage 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. An OIG audit that is currently in progress will provide a national assessment of the proportion of inpatient rehab stays that do not comply with all Medicare coverage and documentation criteria, including stays in hospital-based rehab units and inpatient rehab hospitals.

This report is being issued directly in final form because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-06-16-00360 in all correspondence.

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ENDNOTES

- ¹ Medicare Payment Advisory Commission (MedPAC), *Report to the Congress: Medicare Payment Policy*, March 2014, pp. 185-186.
- ² CMS, *Medicare Benefit Policy Manual*, ch. 1, § 110.2.2. MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2014, p. 244.
- ³ MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2014, p. 171.
- ⁴ The \$12,000 figure for average reimbursement for SNFs is the average of the top and bottom quartiles that MedPAC presented in its *Report to the Congress: Medicare Payment Policy*, March 2014, p. 198.
- ⁵ The \$17,000 figure for average reimbursement for inpatient rehab hospitals is based on OIG analysis of FY 2012 Medicare claims data. See also OIG, *Adverse Events in Rehabilitation Hospitals: National Incidence Among Medicare Beneficiaries*, OEI-06-14-00110, July 2016.
- ⁶ MedPAC, *Report to the Congress: Medicare Payment Policy*, March 2014, p. 243.
- ⁷ All requirements specified in 42 CFR § 412.622(a)(3), (4), and (5) must be met to ensure that inpatient rehab hospital care is reasonable and necessary under Section 1862(a)(1)(A) of the Social Security Act (74 Fed. Reg. 39762, 39788 (Aug. 7, 2009)), as interpreted by the *Medicare Benefit Policy Manual*, ch. 1, § 110.
- ⁸ CMS, *Medicare Benefit Policy Manual*, ch. 1, § 110.2.2.
- ⁹ 42 CFR § 412.622(a)(3)(ii); CMS, *Medicare Benefit Policy Manual*, ch. 1, § 110.2.
- ¹⁰ 42 CFR § 412.622(a)(3); CMS, *Medicare Benefit Policy Manual*, ch. 1, § 110.2.
- ¹¹ CMS, *Medicare Benefit Policy Manual*, ch. 1, § 110.2.2.
- ¹² 42 CFR § 412.622(a)(4); CMS, *Medicare Benefit Policy Manual*, ch. 1, § 110.1.
- ¹³ 42 CFR § 412.622(a)(4)(i); CMS, *Medicare Benefit Policy Manual*, ch. 1, § 110.1.1.
- ¹⁴ 42 CFR § 412.622(a)(4)(ii); CMS, *Medicare Benefit Policy Manual*, ch. 1, § 110.1.2.
- ¹⁵ CMS, *Medicare Benefit Policy Manual*, ch. 1, § 110.1.2. The day of admission is considered the first day.
- ¹⁶ OIG, *Norwalk Hospital Did Not Comply With Medicare Inpatient Rehabilitation Facility Documentation Requirements*, A-01-11-00531, February 2013.
- ¹⁷ OIG, *Medicare Compliance Review of University of Minnesota Medical Center for 2012 and 2013*, A-05-14-00050, January 2016. OIG, *Medicare Compliance Review of Hennepin County Medical Center for 2012 and 2013*, A-05-14-00048, February 2016. OIG, *Medicare Compliance Review of New York Presbyterian Hospital for 2011 and 2012*, A-02-13-01027, August 2016.
- ¹⁸ In our study *Adverse Events in Rehabilitation Hospitals: National Incidence Among Medicare Beneficiaries* (OEI-06-14-00110), we found that an estimated 29 percent of Medicare beneficiaries experienced adverse or temporary harm events during their stays in rehab hospitals.
- ¹⁹ Two of the three physician reviewers also participated as reviewers for the study *Adverse Events in Rehabilitation Hospitals: National Incidence Among Medicare Beneficiaries* (OEI-06-14-00110).