

appropriate to lengthen the patient's stay in an acute care setting in order to stabilize their condition to prepare the patient to participate in rehabilitation. Alternative settings for rehabilitative care could include the acute care hospital, skilled nursing facilities, long-term care hospitals, outpatient rehabilitation, and home health care. For this reason, we do not expect to see reduced access to care for Medicare beneficiaries as a result of improved compliance. In addition, because many hospitals having a Medicare certified IRF unit also have one or more other subunits that provide rehabilitation, revenues from these cases may be generated elsewhere within the same hospital.

We have developed a case study (below) to illustrate the differences in Medicare payment for cases that do not fall into one of the ten conditions included in the 75 percent rule. As discussed above, this type of case could be treated in an alternative setting. For this example, we detail Medicare payment amounts for rehabilitation care in four alternative settings (skilled nursing facility, home health, long term care hospital, and outpatient rehabilitation). As noted above, 80 percent of IRFs are units of hospitals. These hospitals may now choose to direct some patients to other settings. As explained above, it is difficult to predict the approach any individual or group of IRFs will follow in achieving compliance with this regulation, however, the case study illustrates some of the potential Medicare payment effects associated with providing similar levels of rehabilitation in different settings.

Case Example

The following case example has been developed to illustrate the payments under Medicare for levels of rehabilitative care received in the various settings that may be a part of a hospital complex for a patient that has a primary diagnosis of a lower extremity joint replacement. The following case example describes one of the most common patient conditions (not included in the 75 percent rule) but is not meant to describe all possible conditions and their related payment effects. The payments for each PPS described in the example are based on case weights and standardized payment rates for 2003.

The clinical description of the case example is as follows:

A 74-year-old woman status post a right total knee arthroplasty (TKA), with a wound infection, fever, and high white blood count are noted on her second postoperative day.

A work-up indicates the existence of staphylococcus aureus septicemia. Patient lacks full extension and has only 65 degrees of flexion on her third post-operative day. The management options for this patient include: extension of acute care length of stay; transfer to a long term care hospital; admission to a skilled nursing facility; possibly home health services or outpatient services.

Under the IRF PPS, this patient would be classified into case-mix group 804 (lower extremity joint replacement with some functional capabilities) with an average length of stay of 14 days. Furthermore, the existence of staphylococcus aureus septicemia, a comorbid condition (ICD-9-CM code 038.11), would place this patient into the tier 2 payment category. The corresponding 2003 unadjusted payment amount for this patient would be \$10,828.60.

Under the skilled nursing facility (SNF) PPS, this patient is classified into either the very high (RVB) or ultra high (RUB) rehabilitation group based on the hours of therapy she receives per week. We believe that this patient would have a length of stay in the SNF of either 14 days or 20 days. The corresponding 2003 unadjusted payment amount for this patient would be \$4,446.82 for RVB and 14 days, \$6,670.23 for RVB and 20 days, \$6,352.60 for RUB and 14 days, or \$7,672.40 for RUB and 20 days.

Under the long-term care hospital PPS, this patient would be classified into patient group 238 and would have a length of stay of either 14 days or 24 or more days. The corresponding 2003 unadjusted payment amount for this patient would be \$17,671.22 for 14 days or \$28,296.21 for 24 or more days.

Under the home health PPS, this patient would be placed into the High/High/Moderate group. The corresponding 2003 unadjusted payment amount for this patient would be \$5,165.26 for home health services delivered for a 60-day period.

Under outpatient therapy, assuming 2 hours of physical therapy and 1 hour of occupational therapy given during 12 days, payment for this patient would be \$4,108.16

If the patient remained in the original surgical acute care hospital stay, under the inpatient acute care hospital PPS this patient would be classified in to DRG 209 and payment at the 50th percentile would be \$9,047.36. This illustrative example shows that this facility may have lower payments for the care of this patient relative to the IRF PPS payment if this patient is cared for in an SNF or receives home health or outpatient services. However, the facility may have higher payments

relative to the IRF PPS payment if this patient is placed in a long-term care hospital unit. Overall, the example does show that this facility could continue to receive Medicare payments for this type of patient in a setting other than their IRF unit, and have the option of changing its IRF admitting practices without any potential negative effect on patient access to rehabilitative care. However, we invite public comment of this issue.

Section 412.29 Excluded Rehabilitation Units: Additional Requirements

Under § 412.29(a), an IRF unit must have met either the requirements for new units or converted units under § 412.30. Section 412.29(a)(2) contains an incorrect reference to the requirements for converted units as “§ 412.30(b).” The correct reference to the requirements for converted units is § 412.30(c). Accordingly, we are proposing to make a technical correction by changing the reference in paragraph (a)(2) to state “Converted units under § 412.30(c).”

Section 412.30 Exclusion of New Rehabilitation Units and Expansion of Units Already Excluded

Under § 412.30(b)(2), a hospital that seeks exclusion of a new IRF unit may provide written certification that the inpatient population the hospital intends the unit to serve meets the requirements of § 412.23(b)(2). Section 412.30(b)(3) contains an incorrect reference to the required written certification described in “(a)(2)” of this section. The correct reference to the written certification is described in paragraph (2) of § 412.30(b). Accordingly, we are proposing to make a technical correction by changing the current reference to § 412.23(a)(2) in § 412.23(b)(3) to state “The written certification described in paragraph (b)(2) * * *.”

Section 412.30(d)(1) defines new bed capacity for the purposes of expanding an existing excluded IRF unit. Section 412.30(d)(2)(i) contains an incorrect reference to the definition of new bed capacity under paragraph “(c)(1)” of this section. The correct reference to the definition of new bed capacity is paragraph (d)(1). Accordingly, we are proposing a technical correction to change the current reference to paragraph (c)(1) in paragraph (d)(2)(i) to state “* * * under paragraph (d)(1) of this section.”