MINUTES
MEETING OF INPATIENT PHYSICAL REHABILITATION SERVICES TECHNICAL ADVISORY COMMITTEE

Of the Health Strategies Council
2 Peachtree Street, 34th Floor Conference Room, Atlanta, GA 30303

Friday, June 17, 2005
1:00 pm - 3:00 pm

Richard Greene, JD, Presiding

MEMBERS PRESENT

Pamela Cartwright
Patricia Fraley
Kathy Kleinsteuber
John Lindsey (via conference call)
Dennis Skelley, FACHE
Gary Ulicny, Ph.D.
Diane Waldner
Wylene Watts

MEMBERS ABSENT

Donald Avery, FACHE
Harve Bauguess
James Coughenour
Hazel Dorsey, RN
Edwinlyn Heyward
Ron Hunt, M.D.
Jan Marie Popovich
Mary Sloan, MPA
Julia L. Mikell, M.D
Dayna Whitley
Carol Zafiratos

GUESTS PRESENT

Bill Lewis, Lewis Consulting
Kathy Platt, Sullivan Consulting
Helen Sloat, Nelson Mullins
Delores Ware, Gwinnett Health System
Leah Fressell Watkins, Powell Goldstein

STAFF PRESENT

Richard Greene, JD
Matthew Jarrard, MPA
Robert Rozier, JD
Virginia Seery, PhD
Geeta Singh, MHA
Rhathelia Stroud, JD
Stephanie Taylor

WELCOME

The meeting of the Comprehensive Inpatient Physical Rehabilitation Services Technical Advisory Committee (TAC) commenced at 1:05 pm. In the absence of the Chair, Richard Greene presided over the meeting. Mr. Greene welcomed members and guests and introduced two new members, Gary Ulicny, Ph.D., President & CEO, Shepherd Center and Dayna Whitley, Director of Rehabilitation at Coliseum Rehabilitation Center. These new members have replaced Leanne Dennis and Brad Griffin, respectively. Ms. Whitley was absent from today's meeting.

Following his introductory remarks, Mr. Greene called for a motion to approve the minutes of the May 13th meeting. Ms. Waldner said that the "Note" that appears at the top of page 3 of the draft minutes should be positioned on the page to more clearly indicate that it applies to both "adult" and "child" definitions. As it is currently positioned on the draft document, it appears to apply only to the definition of "child". A motion to accept the draft of the May 13th, pending this suggested change, was made by Patricia Fraley, seconded by Diane Waldner. TAC members unanimously approved the minutes,

PUBLIC COMMENTS

Mr. Greene invited guests to provide public comment. No one indicated the desire to speak.

DEVELOPMENT OF GEORGIA'S NEED METHODOLOGY FOR COMPREHENSIVE INPATIENT PHYSICAL REHABILIATION SERVICES

Mr. Greene called upon Matt Jarrard to lead the discussion on the development of the Need Methodology. Mr. Jarrard review the following components of the Need Methodology:

Consensus Regarding Current Inventory of Comprehensive Inpatient Physical Rehabilitation Providers in the State of Georgia

Mr. Jarrard referenced the following documents included in member packets: (see Appendix A)

- Map, Comprehensive Inpatient Physical Rehabilitation Planning Areas and Inventory of Existing and Approved Programs
- Inventory, Comprehensive Inpatient Physical Rehabilitation Programs in Non-Federal Hospitals

He solicited member input regarding the Department's current inventory. A few members indicated that they would provide additional clarifying information to Mr. Jarrard, where discrepancies exist.

There was some general discussion about the accuracy of the inventory of Spinal Cord beds. Members suggested that this area be closely examined to ensure that there is an accurate statewide inventory.

Dr. Ulicny agreed that combining the spinal cord beds with the comprehensive inpatient physical rehabilitation beds in the determination of "need" would be appropriate though to do so might place a burden on The Shepherd Center, since it might not allow The Shepherd Center to expand services to serve patients who live outside of the State of Georgia. He said that The Shepherd Center is a national provider, with roughly 34% of its patient base coming from outside of the Sate of Georgia.

Validation of International Classification of Diseases (ICD 9) Codes from State Health Plan

Mr. Jarrard directed members to the table entitled: "ICD-9 for Diagnostic Categories that May Benefit from Comprehensive Inpatient Physical Rehabilitation Services" (see Appendix B). He reminded members that the Codes in the table have not been updated since the development of the State Health Plan in 1994 and posed the following questions to members:

- Do these Codes represent the types of diagnoses that would need to be admitted to an inpatient rehabilitation facility?
- Are any of these Codes obsolete? Are there new Codes that should be added?

Mr. Greene asked TAC members to provide DCH staff with a set of current reimbursement Codes for Rehabilitation Services. Mr. Skelley agreed to provide a copy of current reimbursement Codes. Dr. Ulicny noted that since Shepherd is licensed as an LTAC, some rehab categories would not apply to this facility. He indicated that he would provide the Codes that would apply to The Shepherd Center. Ms. Waldner said that she would provide appropriate Pediatric Rehab Codes. Mr. Greene asked whether ICD-9 or ICD-10 Codes should be utilized. Mr. Skelley indicated that ICD-9 Codes were still in force and that ICD-10 Codes had not yet been universally adopted.

Discussion of Demand Factor & Average Length of Stay (LOS) in Need Projection

Mr. Jarrard directed members to the following handout included in the meeting folders: (see Appendix C), Table, "Data Elements of the Comprehensive Inpatient Rehabilitation and Spinal Cord Disorders Need Projection Methodology"

Mr. Jarrard pointed out that the ICD Codes are the baseline for the Need projection. He outlined the following considerations in the determination of a Need projection:

CONSIDERATION 1: Discharge Rate/1000

Should the discharge rate for each diagnostic category used in the need projection formula be recalculated whenever new annual discharge data become available?

Mr. Jarrard pointed out that the discharge rate that is currently being utilized in the Need Methodology stems from a 1987 patient origin study. He stated that new discharge data is made available to the Department on an annual basis and that rates could be calculated to update the need projection formula each year.

Mr. Skelley suggested that it would be appropriate to use the yearly discharge data to update the rates used in the Need Methodology. Mr. Rozier indicated that since all other Department Rules indicate that the data should be annually updated, that a similar policy for Comprehensive Inpatient Physical Rehabilitation Services would be appropriate.

Some members suggested that the Need Methodology should use an average of the three most recent years in calculating the discharge rate. Mr. Rozier and Mr. Jarrard pointed out that the current Perinatal Rules require that the Department, on an annual basis, take an average of three years worth of utilization data and compare it to population data.

CONSIDERATION 2: Demand Factor:

- Do the rates that are used in the demand factor in the current State Health Plan still represent appropriate assumptions for the proportion of discharges under each inpatient rehabilitation diagnostic category?
- If new demand factors are recommended, how should they be determined?
- Should the demand factor be updated on any regular basis? If so, under what conditions?

Mr. Jarrard stated that at present, elements of the Need Methodology, including the demand factor, are static. He said that the demand factor has not been updated since the development of the existing plan. He said that the demand factor was determined based, in part, on surveys conducted by an earlier TAC and a review of the demand factors that had been used in other states. He said that if the TAC maintained the current Need formula, a demand factor would be necessary.

Members inquired about approaches that are used in other states. Mr. Rozier noted that there is no trend or uniform approach among other states, as some states utilize a demand based need formula, while others simply state that there will be a specific number of beds/per population. Additionally, some states allow expansion of services if certain utilization standards are met or exceeded. He stated that the Department is unaware of any other state that has a similar formula to that of Georgia's.

CONSIDERATION 3: Average Length of Stay

- Are the expected Average Lengths of Stay (ALOS) set out in the State Health Plan consistent with current treatment environment?
- How often should the ALOS be updated and under what conditions?

Dr. Ulicny stated that he would provide ALOS data and an updated list of ICD Codes for spinal cord programs.

TAC members pointed out that specialty institutions that cater to spinal cord injury or pediatric patients would have ALOS that are much different from other rehab providers. They indicated that these idiosyncrasies should be taken into account in the Need Methodology.

Members suggested that the website (E-rehab.com) could serve as an additional source for rehab data. Ms. Watts suggested that fiscal intermediaries, including Blue Cross Blue Shield of Georgia, might be able to provide additional data.

Mr. Rozier clarified that TAC members should provide Length of Stay (LOS) data by diagnostic groups.

REVIEW OF DRAFT PROPOSED RULES (excluding Service-Specific Need Methodology)

Mr. Rozier reviewed the working Draft of the Proposed Rules (Appendix D).

Applicability (111-2-2-.35 (1)

Mr. Rozier indicated that while the Proposed Rule encompasses the various categories (Comprehensive Inpatient Rehab for Adult and Pediatric Patients, Traumatic Brain Injury -Transitional Living (all ages) and Life Long Living (all ages), and Spinal Cord Injuries (all ages), a separate CON is required for each service.

Dr. Ulicny agreed that spinal cord programs could be included under Adult Comprehensive Inpatient Rehabilitation. He noted that there is great potential for growth at the Shepherd Center, based on the demand for services by patients from outside of the state. He cited the Radiation Therapy Rules, which allow providers to submit an application under the Exception to Need Standard Standard if greater than 30% of a providers' patient base reside outside of the State of Georgia. He said that if the Need Methodology is not sensitive to these types of occurrences, it could indicate that there is no need for additional beds, while in fact a need exists.

Ms. Waldner agreed with this assertion, noting that approximately 25% of the patients at Children's Healthcare of Atlanta are from out of state.

Mr. Rozier asked whether it would be acceptable to have an Exception to Need Standard for providers with a substantial number of patients from out of state. He solicited suggestions as to what that number should be. Some members suggested 25%; while others recommended 30%.

Dr. Ulicny and Ms. Waldner stated that there is an increased need for additional beds, based on demand by out- of- state patients at The Shepherd Center and Children's Healthcare of Atlanta respectively.

Mr. Rozier summed up the discussion and said, based on the TAC's comments, that the Draft Proposed Rules should include a separate category for spinal cord disorders, and should create an Exception to Need Standard for Adult Inpatient Rehab programs that can demonstrate that 30% of their patients come from outside of the State of Georgia and for pediatric providers that 25% of their patients come from outside of the state to access services.

Mr. Greene cautioned members that Rules should be written with a rationale basis and not to address specific concerns of individual institutions.

Ms. Fraley said that TAC members should address the following issues:

- Define a minimum percentage of out of state patients to meet the "Exception to Need" standard
- Consider an exception standard for facilities that offer services not offered elsewhere in the state
- Address the issue of patient choice

Mr. Rozier noted that "exceptions for facilities that offer services not offered elsewhere in the state" could be addressed under the "Quality" section of the Proposed Rules.

Mr. Skelley pointed out that if a provider met stipulated occupancy rates, regardless of where their patient base is derived, current Administrative Rules allow the addition of 10 beds or 10% of CON approved beds without the need to obtain a CON.

Dr. Ulicny expressed concern about the use of the Administrative Rule to increase the number of beds, stating that it is not cost-effective to increase a facility by 10 beds. He added that this is why the exception standard is very important.

Mr. Rozier asked for consensus regarding the following:

- Whether to combine items 111-2-2-.35 (1)(a) and 111-2-2-.35 (1)(e)
- Whether TBI Transitional Living and Life Long Living Program should require separate CONs and separate need methodologies 111-2-2-.35 (1)(c) and 111-2-2-.35 (1)(d) of the Proposed Rules.

Following committee discussion, Mr. Rozier summarized the points agreed to by the TAC as it relate to the Applicability section of the Proposed Rules:

- 111-2-2-.35 (1)(a) and 111-2-2-.35 (1)(e) will be combined into one program
- 111-2-2-.35 (1) (b) will remain as a separate program
- 111-2-2-.35 (1)(c) and 111-2-2-.35(1)(d) will be combined into one program

Definitions- 111-2-2-.35 (2)
Mr. Rozier reviewed the Definitions portion of the Proposed Rules.

- 111-2-2-.35 (2)(a) "Adult"

There was some concern about the definition of "adult" though the TAC had previously agreed to the proposed definition.

Dr. Ulicny indicated that because the spinal cord program was not previously combined with the Adult Comprehensive Inpatient Physical Rehab program, the definition would have to be changed. He indicated that The Shepherd Center accepts patients with spinal cord injuries ranging from 12 years and above.

Some members suggested that patient choice might be another factor to consider in the age determination.

- 111-2-2-.35 (2)(b) Comprehensive Inpatient Physical Rehabilitation Program

Mr. Rozier noted that this proposed definition is the same as that in the current Rules. He noted that this definition was not discussed at previous meetings. Members were encouraged to review the definition and to provide any necessary feedback prior to or at the next meeting.

- 111-2-2-.35 (2)(c) Expansion and Expanded

Mr. Rozier summarized that the proposed new definition allows freestanding facilities to expand every two years without CON review if an average occupancy of 85% is maintained. He pointed out that the two-year time period is consistent with the statutory exemption.

- 111-2-2-.35 (2)(d) Freestanding Rehabilitation Hospital

The proposed definition is the same as that in the current Comprehensive Inpatient Physical Rehab Rules.

- 111-2-2-.35 (2)(e) New

Members agreed to the proposed definition of "new" services.

- 111-2-2-.35 (2)(g) Pediatric

Mr. Rozier reminded members that there would be "Exception to the Need" standard added for spinal cord patients stating that all ages of patients are acceptable.

Dr. Ulicny disapproved of the proposed definition of "pediatric", stating that The Shepherd Center has a history of serving patients 12 years and over, though they are not considered "pediatric" providers. He said

that the age admission criteria (12 years and up) at The Shepherd Center applies towards all rehab services, not just spinal cord patients.

Ms. Waldner said that she believed that the "pediatric" category was necessary, because as in Children's Healthcare of Atlanta, it cannot exist as a freestanding rehab unit without the support services of an acute care hospital.

Ms. Kleinsteuber asserted that her biggest concern is that there is an access issue in South Georgia, and there are children that cannot be easily transported to the City of Atlanta that have been referred to local facilities. These facilities cannot legally turn away pediatric patients because they are not "pediatric" providers. She stated that her facility, on many occasions, has served patients ages 12-15 out of medical necessity.

Mr. Greene suggested that perhaps a facility would be allowed to treat patients regardless of age if the treatment is "medical necessary". He said that this should be the exception and not the rule.

Following extensive committee discussion, no consensus was reached on the definition.

Mr. Rozier suggested moving on to the next section and coming back to this definition at the next meeting.

- 111-2-2-.35 (2)(i)(j)(k)(l) TBI Injury, TBI Facility, TBI Injury Life Long Living (all ages) Program, TBI Transitional Living (all ages) Program

Mr. Rozier indicated that these definitions were taken directly from the current TBI Rule. He encouraged members to review these definitions and to provide any suggested changes at the next meeting. He noted that, based on the TAC's decision during today's meeting, items 111-2-2-.35 (2)(k) and111-2-2-.35 (2)(l) would be combined into one TBI program.

Mr. Skelley stated that there are several Assisted Living facilities in the state that care for people that have TBI diagnoses. He inquired as to whether they would be in violation of this Proposed Rule.

Mr. Greene noted that it would depend on the level of care that the facility is providing and whether the facilities received Waivers from the Department of Human Resources. He said that this issue has grown and some legislation would likely come out of next year's General Assembly.

Service-Specific Review Standards 111-2-2-.35 (3)

Mr. Rozier noted that a step by step, Need Methodology has not been developed at this time but would be included as soon as it is developed.

Mr. Rozier asked Mr. Skelley about the reasoning behind the language in item111-2-2-.35 (3)(c), as the current rule allows an Exception to Need Standard Methodology for adult programs to be located in a county with a population of less than 40,000, if they are at least 50 miles from an existing program. Mr. Skelley indicated that during the time when the earlier TAC met there were geographic access issues to rehab services. Many rural community hospitals felt that they had the ability to provide this service and their communities were denied access to these services. He indicated that the distance used to be 90 miles.

Mr. Rozier said that 111-2-2-.35 (3)(c) is a geographic accessibility measure. He asked whether this standard is still appropriate in today's market.

Ms. Cartwright indicated that a 45-minute ride to receive rehab services on a regular basis is a considerably lengthy drive.

Mr. Lindsay noted that this Proposed Rule would apply to any small rural community.

Given time constraints, Mr. Rozier quickly reviewed the remainder of the Draft Proposed Rules including:

- 111-2-2-.35 (3)(d) - Minimum bed sizes for new programs: Are these still valid?
- 111-2-2-.35 (3)(e) & (3)(f) - Accreditation Standards: Items already agreed to by the TAC
- 111-2-2-.35 (3)(g) - TBI Licensure Standards: Members to review & provide any necessary feedback
- 111-2-2-.35 (3)(h)(i) - Quality Standards: Same as the current existing rules, as per TAC's decision
- 111-2-2-.35 (3)(j)(k) - Financial Access: Review and provide input
- 111-2-2-.35 (3)(l) - Geographical Distribution - Needs additional detail
- 111-2-2-.35 (3)(m) - Information Requirements - Same as the current Rules, per TAC's decision

FUTURE MEETING

The next TAC meeting is scheduled for **Friday, July 29, at 2 Peachtree Street, Atlanta, 34th Floor Conference Room from 1:00 pm-3:00 pm.**

Ms. Taylor reminded members to submit all information, feedback, and data to the Department no later than June 30th. Mr. Greene thanked all members for their participation in today's meeting. The meeting adjourned at 3:07 pm.

Minutes taken on behalf of Chair by Geeta Singh and Stephanie Taylor.

Respectfully Submitted,
Richard Greene (on behalf of Harve Bauguess, Chair)

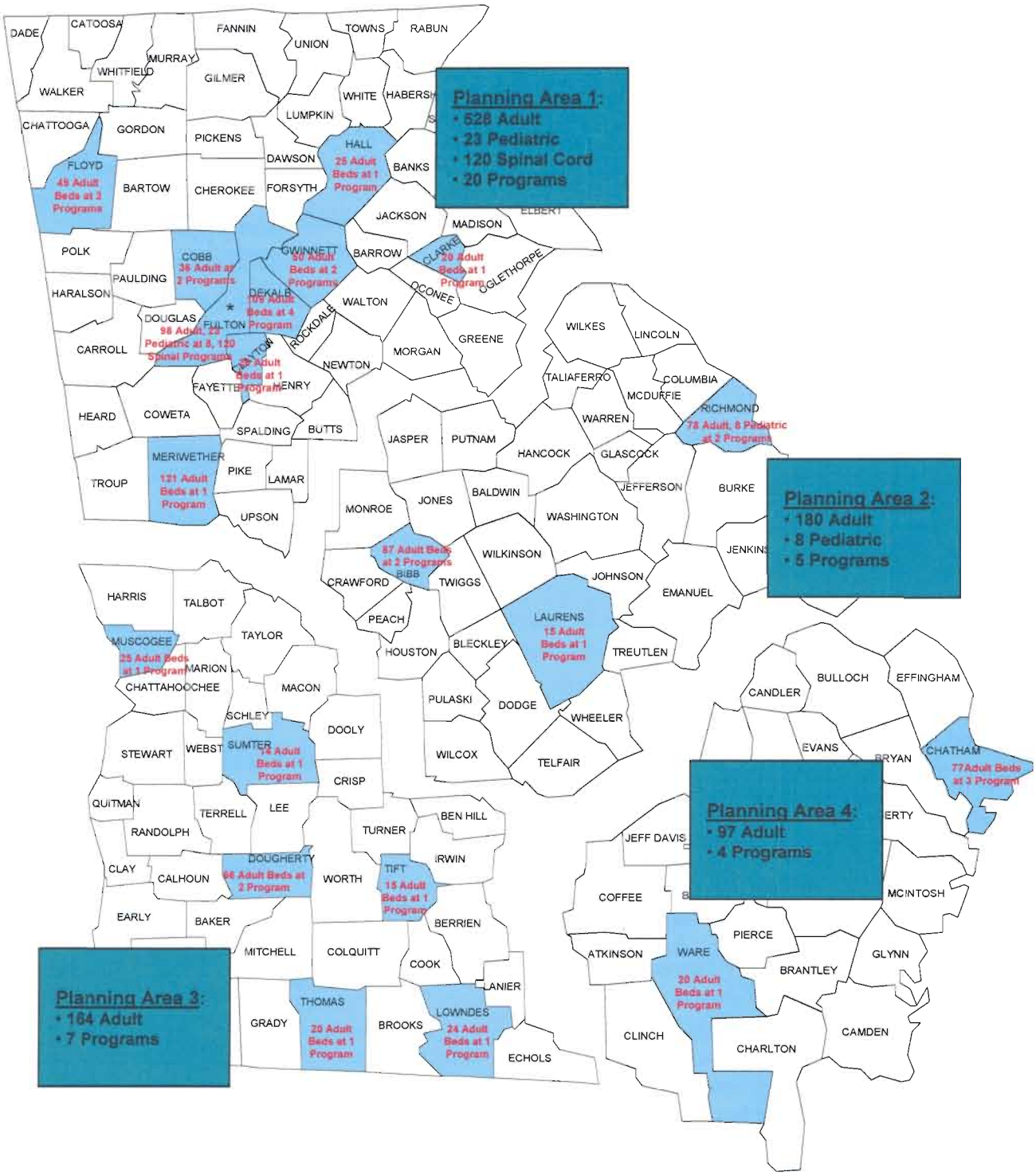
MINUTES
MEETING OF INPATIENT PHYSICAL REHABILITATION SERVICES
TECHNICAL ADVISORY COMMITTEE

Friday, June 17, 2005

APPENDIX A

Comprehensive Inpatient Physical Rehabilitation Planning Areas and Inventory of Existing and Approved Programs
&
Inventory, Comprehensive Inpatient Physical Rehabilitation Programs in Non-Federal Hospitals

Comprehensive Inpatient Physical Rehabilitation Planning Areas and Inventory of Existing and Approved Programs



Prepared by: Data Resources and Analysis Section,
Division of Health Planning – June 17, 2005

Comprehensive Inpatient Physical Rehabilitation Programs in Non-Federal Hospitals

				Adult			Pediatric			Spinal			Total		
Type	HPA	County	Facility Name	Existing	Pending	Total	Existing	Pending	Total	Existing	Pending	Total	Existing	Pending	Total
CIPR Planning Area 1															
General	4	Clarke	St. Mary's Hospital	20	0	20	0	0	0	0	0	0	20	0	20
General	3	Clayton	Southern Regional Medical Center	0	20	20	0	0	0	0	0	0	0	20	20
General	3	Cobb	WellStar Cobb Hospital	16	0	16	0	0	0	0	0	0	16	0	16
General	3	Cobb	WellStar Kennestone Hospital	20	0	20	0	0	0	0	0	0	20	0	20
General	3	DeKalb	DeKalb Medical Center	25	0	25	0	0	0	0	0	0	25	0	25
General	3	DeKalb	Emory University Hospital	56	0	56	0	0	0	0	0	0	56	0	56
General	3	DeKalb	Northlake Medical Center, LLC	12	0	12	0	0	0	0	0	0	12	0	12
General	3	DeKalb	Wesley Woods Geriatric Hospital	16	0	16	0	0	0	0	0	0	16	0	16
General	1	Floyd	Floyd Medical Center	29	0	29	0	0	0	0	0	0	29	0	29
General	1	Floyd	Redmond Regional Medical Center	20	0	20	0	0	0	0	0	0	20	0	20
General	3	Fulton	Atlanta Medical Center	30	0	30	0	0	0	0	0	0	30	0	30
General	3	Fulton	Children's Healthcare of Atlanta at Scottish Rite	0	0	0	23	0	23	0	0	0	23	0	23
General	3	Fulton	North Fulton Regional Hospital	33	0	33	0	0	0	0	0	0	33	0	33
General	3	Fulton	Piedmont Hospital	15	0	15	0	0	0	0	0	0	15	0	15
General	3	Fulton	South Fulton Medical Center	20	0	20	0	0	0	0	0	0	20	0	20
General	3	Gwinnett	Emory Eastside Medical Center	0	20	20	0	0	0	0	0	0	0	20	20
General	3	Gwinnett	Joan Glancy Memorial Hospital	30	0	30	0	0	0	0	0	0	30	0	30
General	2	Hall	Northeast Georgia Medical Center	25	0	25	0	0	0	0	0	0	25	0	25
	18	**Facilities**	**Total**	**367**	**40**	**407**	**23**	**0**	**23**	**0**	**0**	**0**	**390**	**40**	**430**
CIPR Planning Area 2															
General	6	Bibb	Coliseum Medical Centers	29	0	29	0	0	0	0	0	0	29	0	29
Specialty	6	Bibb	HealthSouth Central Georgia Rehabilitation Hospital	55	3	58	0	0	0	0	0	0	55	3	58
General	9	Laurens	Fairview Park Hospital	15	0	15	0	0	0	0	0	0	15	0	15
General	7	Richmond	Doctor's Hospital of Augusta	28	0	28	0	0	0	0	0	0	28	0	28
Specialty	7	Richmond	Walton Rehabilitation Hospital	50	0	50	8	0	8	0	0	0	58	0	58
	5	**Facilities**	**Total**	**177**	**3**	**180**	**8**	**0**	**8**	**0**	**0**	**0**	**185**	**3**	**188**

Type	HPA	County	Facility Name	Adult Existing	Adult Pending	Adult Total	Pediatric Existing	Pediatric Pending	Pediatric Total	Spinal Existing	Spinal Pending	Spinal Total	Total Existing	Total Pending	Total Total
CIPR Planning Area 3															
General	11	Dougherty	Palmyra Medical Centers	48	0	48	0	0	0	0	0	0	48	0	48
General	11	Dougherty	Phoebe Putney Memorial Hospital	18	0	18	0	0	0	0	0	0	18	0	18
General	12	Lowndes	South Georgia Medical Center	24	0	24	0	0	0	0	0	0	24	0	24
General	8	Muscogee	Hughston Orthopedic Hospital	25	0	25	0	0	0	0	0	0	25	0	25
General	8	Sumter	Sumter Regional Hospital, Inc.	12	2	14	0	0	0	0	0	0	12	2	14
General	11	Thomas	John D. Archbold Memorial Hospital	20	0	20	0	0	0	0	0	0	20	0	20
General	12	Tift	Tift Regional Medical Center	15	0	15	0	0	0	0	0	0	15	0	15
	7	**Facilities**	**Total**	**162**	**2**	**164**	**0**	**0**	**0**	**0**	**0**	**0**	**162**	**2**	**164**
CIPR Planning Area 4															
General	10	Chatham	Candler Hospital	23	0	23	0	0	0	0	0	0	23	0	23
General	10	Chatham	Memorial Health University Medical Center	30	0	30	0	0	0	0	0	0	30	0	30
General	10	Chatham	St. Joseph's Hospital	24	0	24	0	0	0	0	0	0	24	0	24
General	13	Ware	Satilla Regional Medical Center	20	0	20	0	0	0	0	0	0	20	0	20
	4	**Facilities**	**Total**	**97**	**0**	**97**	**0**	**0**	**0**	**0**	**0**	**0**	**97**	**0**	**97**
Other															
Specialty	3	Fulton	Shepherd Center	0	0	0	0	0	0	100	20	120	100	20	120
State Spe	5	Meriwether	Roosevelt Warm Springs Institute for Rehabilitation	121	0	121	0	0	0	0	0	0	121	0	121
	2	**Facilities**	**Total**	**121**	**0**	**121**	**0**	**0**	**0**	**100**	**20**	**120**	**221**	**20**	**241**
			Planning Area Total	**803**	**45**	**848**	**31**	**0**	**31**	**0**	**0**	**0**	**834**	**45**	**879**
			Grand Total	**924**	**45**	**969**	**31**	**0**	**31**	**100**	**20**	**120**	**1,055**	**65**	**1,120**

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APPENDIX B

ICD-9 Codes for Diagnostic Categories that May Benefit from Comprehensive Inpatient Physical Rehabilitation Services

ICD-9 Codes for Diagnostic Categories that May Benefit from Comprehensive Inpatient Physical Rehabilitation Services

Diagnostic Category	Specified ICD-9 Codes in CIPR Component Plan
Arthritis/Joint	*714, 720, 721*
Chronic Pain	*722, 723, 724, 729.1, 729.5, 784.0*
Non-Traumatic Brain Injury	*191, 192.0 to 192.1, 198.3, 225.0 to 225.2, 239.6, 310.2, 324.0, 330, 331, 333.1 to 333.8, 337, 348.0 to 348.1, 348.3 to 348.4, 742.0, 768.9, 997.0*
Neurologic Disorders	*192.8 to 192.9, 198.4, 237.5 to 237.9, 239.7, 250.6, 320, 321, 322, 323, 332, 333.0, 333.9, 334, 340, 341, 343, 349.2, 349.8, 356, 357.0 to 357.1, 357.3 to 357.4, 357.7 to 357.9, 358, 359.0 to 359.4, 359.6, 359.8 to 359.9, 953, 954, 955, 956, 957*
Orthopedic Disorders	*710, 726, 754, 755, 756.5, 805, 808, 820, 827, 828, 839.0 to 839.5, 839.8 to 839.9, 887, 896, 897, 905.1, 905.5, 905.9, 908.3, 908.6, 929, 81.41, 81.51, 81.59, 84.09, 84.10, 84.12, 84.15, 84.16, 84.17, 84.18, 84.19, 84.24, 84.27, 84.28, 84.29, 84.44, 84.45, 84.46*
Spinal Cord Disorders	*170.2, 192.2 to 192.3, 225.3 to 225.4, 324.1, 324.9, 335, 336, 741, 767.4, 806, 952*
Stroke	*430, 431, 432, 433, 434.0, 434.1, 434.9 436, 437.3, 441.0-441.5, 441.9, 442.0 to 442.3, 442.8 to 442.9, 747.6, 767.0*
Traumatic Brain Injury	*800.1 to 800.4, 800.6 to 800.9, 801, 803.1 to 803.4, 803.6 to 803.9, 804.1 to 804.41, 804.6 to 804.9, 850.1 to 850.9, 851, 852, 853, 854, 907.0 to 907.11, 907.3 to 907.9*

For Consideration

Do these ICD-9 codes continue to represent the types of diagnoses that would tend to need an inpatient rehabilitation bed?

Are any of these codes obsolete or are there new codes that are not listed here that may also apply to inpatient rehabilitation services?

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Friday, June 17, 2005

APPENDIX C

Data Elements of the Comprehensive Inpatient Physical Rehabilitation and Spinal Cord Disorders Need Projection Methodology

Data Elements of the Comprehensive Inpatient Physical Rehabilitation and Spinal Cord Disorders Need Projection Methodology

Spinal Cord Disorders (All Ages)

Diagnostic Group	1987 Georgia Hospital Discharge Rate/1000	Assumed Demand/ Need Factor	Expected Average Length of Stay
Spinal Cord Disorders	0.34	40%	32

Inpatient Physical Rehabilitation Programs for Ages 0-14

Diagnostic Group	1987 Georgia Hospital Discharge Rate/1000	Assumed Demand/ Need Factor	Expected Average Length of Stay
Stroke	0.13	100%	12
Neurosystem Disorders	0.69	4%	21
Traumatic Brain Injury	1.13	8%	30
Non-traumatic Brain Injury	0.51	8%	30
Arthritis (Poly and Rheumatoid)	0.07	2%	5
Orthopedic Disorders	1.04	25%	20
Chronic Pain	0.14	0%	0

Inpatient Physical Rehabilitation Programs for Ages 15 and Up

Diagnostic Group	1987 Georgia Hospital Discharge Rate/1000	Assumed Demand/ Need Factor	Expected Average Length of Stay
Stroke	3.89	20%	25
Neurosystem Disorders	1.13	1%	20
Traumatic Brain Injury	1.23	2%	40
Non-traumatic Brain Injury	1.19	2%	40
Arthritis (Poly and Rheumatoid)	1.31	5%	19
Orthopedic Disorders	4.06	5%	20
Chronic Pain	7.74	1%	12

For Consideration

Discharge Rate/1000

Should the discharge rate be recalculated and applied to the need projection formula whenever new annual discharge data become available?

Demand Factor

Do the Demand Factor rates that were set out in the existing Component Plan still represent appropriate assumptions for the proportion of discharges under each diagnostic category that would tend to benefit from an inpatient rehabilitation bed?

If new Demand Factor rates should be set how should these be determined?

Should the Demand Factor rates be adjusted or updated on any regular basis? If so, under what conditions?

Average Length of Stay

For the types of cases from each diagnostic category are the expected average lengths of stay set out in the Component Plan consistent with current treatment environments?

How often should the ALOS be updated and under what conditions?

MINUTES
MEETING OF INPATIENT PHYSICAL REHABILITATION SERVICES
TECHNICAL ADVISORY COMMITTEE

Friday, June 17, 2005

APPENDIX D

WORKING DRAFT PROPOSED RULES

WORKING DRAFT PROPOSED RULES
OF
DEPARTMENT OF COMMUNITY HEALTH

111-2
HEALTH PLANNING

111-2-2
Certificate of Need

111-2-2-.35 Specific Review Considerations for Comprehensive Inpatient Physical Rehabilitation Services

(1) **Applicability.**

(a) A Certificate of Need shall be required prior to the establishment of a new or the expansion of an existing Comprehensive Inpatient Physical Rehabilitation Adult Program. An application for Certificate of Need for a new or expanded Comprehensive Inpatient Physical Rehabilitation Adult Program shall be reviewed under the General Review Considerations of Rule 111-2-2-.09 and the service-specific review considerations of this Rule.

(b) A Certificate of Need shall be required prior to the establishment of a new or the expansion of an existing Comprehensive Inpatient Physical Rehabilitation Pediatric Program. An application for Certificate of Need for a new or expanded Comprehensive Inpatient Physical Rehabilitation Pediatric Program shall be reviewed under the General Review Considerations of Rule 111-2-2-.09 and the service-specific review considerations of this Rule.

Should TBI Transitional Living and Life Long Living Program Require Separate CONs and Separate Need Methodologies?

(c) A Certificate of Need shall be required prior to the establishment of a new or the expansion of an existing Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Transitional Living (All Ages) Program. An application for Certificate of Need for a new or expanded Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Transitional Living (All Ages) Program shall be reviewed under the General Review Considerations of Rule 111-2-2-.09 and the service-specific review considerations of this Rule.

(d) A Certificate of Need shall be required prior to the establishment of a new or the expansion of an existing Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Life Long Living (All Ages) Program. An application for Certificate of Need for a new or expanded Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Life Long Living (All Ages) Program shall be reviewed under the General Review Considerations of Rule 111-2-2-.09 and the service-specific review considerations of this Rule.

(e) A Certificate of Need shall be required prior to the establishment of a new or the expansion of an existing Comprehensive Inpatient Physical Rehabilitation Spinal Cord Disorders (All Ages) Program. An application for Certificate of Need for a new or expanded Comprehensive Inpatient Physical Rehabilitation Spinal Cord Disorders (All Ages) Program shall be reviewed under the General Review Considerations of Rule 111-2-2-.09 and the service-specific review considerations of this Rule.

(2) **Definitions.**

New Definition of Adult: 18+ For Medical Necessity: 16+

(a) 'Adult' means persons eighteen years of age and over. However, in no case shall a CON-authorized Comprehensive Inpatient Physical Rehabilitation Adult Program be in violation of the CON laws and regulations if it provides service to a patient older than fifteen years if the provider has determined that such service is medically necessary.

(b) 'Comprehensive Inpatient Physical Rehabilitation Program' means rehabilitation services provided to a patient who requires hospitalization, in that the patient has one or more medical conditions requiring intensive and interdisciplinary rehabilitation care, or has a medical complication in addition to the primary condition, so that the continuing availability of a physician is required to ensure safe and effective treatment. Throughout this Rule, whenever this general term is used, it refers to the full spectrum of programs delineated in Rule 111-2-2-.35(1)(a) through (e).

New Definition of Expansion: Allows freestanding facilities to expand every two years without CON review if 85% Occupancy

(c) 'Expansion' and 'Expanded' mean the addition of beds to an existing CON-authorized Comprehensive Inpatient Physical Rehabilitation Program. However, a CON-authorized provider of Comprehensive Inpatient Physical Rehabilitation in a freestanding rehabilitation hospital or a traumatic brain injury facility may increase the bed capacity of an existing program by the lesser of ten percent of existing capacity or 10 beds if it has maintained an average occupancy of 85 percent for the previous twelve calendar months provided that there has been no such increase in the prior two years and provided that the capital expenditures associated with the increase do not exceed the capital expenditure threshold. If such an increase exceeds the capital expenditure threshold, the increase will be considered an expansion for which a Certificate of Need shall be required under these Rules.

(d) 'Freestanding Rehabilitation Hospital' means a specialized hospital organized and operated as a self-contained health care facility that provides one or more rehabilitation programs.

New Definition of New

(e) 'New' means a Program that has not provided Comprehensive Inpatient Physical Rehabilitation in the previous twelve months. Each of the programs described in 111-2-2-.35(1)(a) through (e) shall be considered independent programs such that a provider seeking to add a program not offered by that provider in the previous twelve months shall

be considered to be offering a new program for which a Certificate of Need must be obtained.

(f) 'Official State Health Component Plan' means the document related to Physical Rehabilitation Programs and Services developed by the Department, established by the Georgia Health Strategies Council and signed by the Governor of Georgia.

New Definition of Pediatric: 17- For Medical Necessity: 21-

(g) 'Pediatric' means persons seventeen years of age and under. However, in no case shall a CON-authorized Comprehensive Inpatient Rehabilitation Pediatric Program be in violation of the CON laws and regulations if it provides service to a patient younger than twenty-two years if the provider has determined that such service is medically necessary.

(h) 'Planning Area' means sub-state region for Physical Rehabilitation Programs and Services, as defined in the most recent official State Health Component Plan for Physical Rehabilitation Programs and Services.

Definitions Copied From Current TBI Rule

(i) 'Traumatic Brain Injury' means a traumatic insult to the brain and its related parts resulting in organic damage thereto that may cause physical, intellectual, emotional, social, or vocational changes in a person. It shall also be recognized that a person having a traumatic brain injury may have organic damage or physical or social disorders, but shall not be considered mentally ill.

(j) 'Traumatic Brain Injury Facility' means a building which is devoted to the provision of residential treatment and rehabilitative care in a transitional living program or a life long living program for periods continuing for 24 hours or longer for persons who have traumatic brain injury. Such a facility is not classified by the Georgia Department of Human Resources or the Department of Community Health as a hospital, nursing home, intermediate care facility or personal care home.

(k) 'Traumatic Brain Injury Life Long Living (All Ages) Program' means such treatment and rehabilitative care as shall be delivered to traumatic brain injury clients who have been discharged from a more intense level of rehabilitation program, but who cannot live at home independently, and who require on-going lifetime support. Such clients are medically stable, may have special needs, but need less than 24 hour per day medical support.

(l) 'Traumatic Brain Injury Transitional Living (All Ages) Program' means such treatment and rehabilitative care as shall be delivered to traumatic brain injury clients who require education and training for independent living with a focus on compensation for skills which cannot be restored. Such care prepares clients for maximum independence, teaches necessary skills for community interaction, works with clients on pre-

vocational and vocational training and stresses cognitive, speech, and behavioral therapies structured to the individual needs of clients. Such clients are medically stable, may have special needs, but need less than 24 hour per day medical support.

(3) **Service-Specific Review Standards.**

Step By Step Methodology: To Be Determined

(a) The need for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall be determined and applied as follows for the various types of Programs delineated in 111-2-2-.35(1):

1. The need for new or expanded Comprehensive Inpatient Physical Rehabilitation Adult Program in a planning area shall be determined [Methodology TO BE Described]

2. The need for new or expanded Comprehensive Inpatient Physical Rehabilitation Pediatric Program in a planning area shall be determined [Methodology TO BE Described]

3. The need for new or expanded Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Life Long Living (All Ages) Program in a planning area shall be determined [Methodology TO BE Described]

4. The need for new or expanded Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Transitional Living (All Ages) Program in a planning area shall be determined [Methodology TO BE Described]

5. The need for new or expanded Comprehensive Inpatient Physical Rehabilitation Spinal Cord Disorders (All Ages) Program in a planning area shall be determined [Methodology TO BE Described]

Adverse Impact Standard: Will Cause a Facility to Drop 10% Utilization

(b) An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall document that the establishment or expansion of its program will not have an adverse impact on existing and approved programs of the same type in its planning area. An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall have an adverse impact on existing and approved programs of the same type if it will decrease annual utilization by ten percent by the horizon year. The applicant shall provide evidence of projected impact by taking into account existing planning area market share of programs of the same type and future population growth.

Exception to Need and Adverse Impact: Only for Adult Programs? To Be Discussed

(c) The Department may grant an exception to the need methodology of 111-2-2-.35(3)(a)1 and to the adverse impact standard of 111-2-2-.35(3)(b) for an applicant proposing an adult program to be located in a county with a population of less than 40,000 and to be located a minimum of 50 miles away from any existing adult program in the state; or to remedy an atypical barrier to Comprehensive Inpatient Physical Rehabilitation Adult Programs based on cost, quality, financial access or geographic accessibility.

(d) A new Comprehensive Inpatient Physical Rehabilitation Program shall have the following minimum bed sizes based on type of Program offered:

Minimum Bed Sizes for New Programs: To be Discussed and Verified

1. A new Comprehensive Inpatient Physical Rehabilitation Adult Program shall have a minimum bed size of 20 beds in a freestanding rehabilitation hospital already offering another Comprehensive Inpatient Physical Rehabilitation Program, 20 beds in an acute-care hospital, and 40 beds for a new freestanding rehabilitation hospital not already offering another Comprehensive Inpatient Physical Rehabilitation Program.

2. A new Comprehensive Inpatient Physical Rehabilitation Pediatric Program shall have a minimum of 10 beds in a freestanding rehabilitation hospital already offering another Comprehensive Inpatient Physical Rehabilitation Program, 10 beds in an acute-care hospital, and 40 beds for a new freestanding rehabilitation hospital not already offering another Comprehensive Inpatient Physical Rehabilitation Program.

3. A new Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Transitional Living Program shall have a minimum of 6 beds in a freestanding rehabilitation hospital already offering another Comprehensive Inpatient Physical Rehabilitation Program, 6 beds in an acute-care hospital, 6 beds for a new freestanding rehabilitation hospital not already offering another Comprehensive Inpatient Physical Rehabilitation Program, and 6 beds in a Traumatic Brain Injury Facility. A Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Life Long Living Program may not have more than 30 beds unless the applicant provides documentation satisfactory to the Department that the program design, including staffing patterns and the physical plant, are such as to promote services which are of high quality, are cost-effective and are consistent with client needs.

4. A new Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Life Long Living Program shall have a minimum of 6 beds in a freestanding rehabilitation hospital already offering another Comprehensive Inpatient Physical Rehabilitation Program, 6 beds in an acute-care hospital, 6 beds for a new freestanding rehabilitation hospital not already offering another Comprehensive Inpatient Physical Rehabilitation Program, and 6

beds in a Traumatic Brain Injury Facility. A Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Life Long Living Program may not have more than 30 beds unless the applicant provides documentation satisfactory to the Department that the program design, including staffing patterns and the physical plant, are such as to promote services which are of high quality, are cost-effective and are consistent with client needs.

5. A new Comprehensive Inpatient Physical Rehabilitation Spinal Cord Disorders Program shall have a minimum of 20 beds in a freestanding rehabilitation hospital already offering another Comprehensive Inpatient Physical Rehabilitation Program, 20 beds in an acute-care hospital, and 40 beds for a new freestanding rehabilitation hospital not already offering another Comprehensive Inpatient Physical Rehabilitation Program.

Accreditation Standards

(e) An applicant for a new Comprehensive Inpatient Physical Rehabilitation Program shall demonstrate the intent to meet the standards of the Commission on Accreditation of Rehabilitation Facilities ("CARF") applicable to the type of Program to be offered within 36 months of offering the new service.

(f) An applicant for an expanded Comprehensive Inpatient Physical Rehabilitation Program shall be accredited by the Commission on Accreditation of Rehabilitation Facilities ("CARF") for the type of Program which the applicant seeks to expand prior to application. The applicant must provide proof of such accreditation.

TBI Licensure Standards

(g) An applicant for a new Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Transitional Living (All Ages) Program and/or a new Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Life Long Living (All Ages) Program in a Traumatic Brain Injury Facility shall demonstrate the intent to meet the licensure Rules of the Georgia Department of Human Resources for Traumatic Brain Injury Facilities (Chapter 290-5-53). An applicant for an expanded Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Transitional Living (All Ages) Program and/or an expanded Comprehensive Inpatient Physical Rehabilitation Traumatic Brain Injury Life Long Living (All Ages) Program in a Traumatic Brain Injury Facility shall demonstrate a lack of uncorrected deficiencies as documented by letter from the Georgia Department of Human Resources.

(h) An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall have written policies and procedures for utilization review. Such review shall consider, but is not limited to, factors such as medical necessity, appropriateness and efficiency of services, quality of patient care, and rates of utilization.

(i) An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program in a Freestanding Rehabilitation Hospital or Traumatic Brain Injury Facility shall document the existence of referral arrangements with an acute-care hospital(s) within the planning area to provide acute and emergency medical treatment to any patient who requires such care.

(j) An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall foster an environment that assures access to services to individuals unable to pay and regardless of payment source or circumstances by the following:

1. providing evidence of written administrative policies and directives related to the provision of services on a nondiscriminatory basis;

2. providing a written commitment that un-reimbursed services for indigent and charity patients in the service will be offered at a standard which meets or exceeds three percent of annual gross revenues for the service after Medicare and Medicaid contractual adjustments and bad debt have been deducted;

3. providing documentation of the demonstrated performance of the applicant, and any facility in Georgia owned or operated by the applicant's parent organization, of providing services to individuals unable to pay based on the past record of service to Medicare, Medicaid, and indigent and charity patients, including the level of un-reimbursed indigent and charity care; and

4. providing documentation of current or proposed charges and policies, if any, regarding the amount or percentage of charges that charity patients, self pay patients, and the uninsured will be expected to pay.

Additional Financial Accessibility Standards

A provider offering more than one program in Comprehensive Inpatient Physical Rehabilitation may make one written commitment for the entire service as opposed to several commitments for the various programs within the service; however, an acute care hospital may not substitute an institution-wide commitment in lieu of this service-specific commitment.

k. In addition to the requirements of 111-2-2-.35(3)(j) an applicant for an expanded Comprehensive Inpatient Physical Rehabilitation Program shall be meeting or exceeding any and all previous commitments to indigent and charity care. If the applicant has not provided the level of indigent and charity care services sufficient to meet such commitments, the applicant may satisfy this requirement by paying a fine equal to the difference in the amount of services provided and the commitment made.

To be discussed

l. A new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall be developed in a manner that improves the distribution of beds for similar Programs, existing or approved, within the planning area based on geographic and demographic characteristics.

m. An applicant for a new or expanded Comprehensive Inpatient Physical Rehabilitation Program shall agree to provide the Department with requested information and statistical data related to the operation of such a Program on a yearly basis, or as needed, and in a format requested by the Department.