THE BURKE REHABILITATION HOSPITAL

February 4, 2009

Julie M. Stankvic
Health Insurance Specialist
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mail Stop C5-06-27
Baltimore, Maryland 21244

Dear Ms. Stankvic:

Thank you for the opportunity to provide input on the Medicare Classification Criteria for Inpatient Rehabilitation Facilities (IRFs).

Burke Rehabilitation Hospital is a 150 bed facility, free-standing, in White Plains, NY. We are an academic affiliate of the Weill Medical College of Cornell University. We have provided hospital post-acute care to patients with functional limitations after illness of injury since 1915.

Medicare beneficiaries' access to medically necessary rehabilitation services has been limited as a result of the implementation of the 75%, or current 60% rule. The criteria used for classification of an inpatient rehabilitation facility include the percentage of patients with certain diagnoses. Diagnosis is not a suitable indicator of an individual patient's need for intensive inpatient rehabilitation, which addresses primarily their functional limitations, regardless of particular diagnostic label. Every IRF must monitor the diagnoses of patients admitted to ensure compliance. Thus, an 83 year old, frail widow with a total hip replacement performed after being restricted in her ambulation ability for a considerable period of time might be admitted in one month, and refused in another month depending on the complement of diagnoses admitted that year by that particular facility. A patient who had been diagnosed with a malignancy, and was functioning independently, might undergo extensive surgery and chemotherapy, with a long hospital stay; although his tumor is in remission, he can no longer walk independently, get out of bed, or perform even basic activities of daily living without help. Surely the appropriate intervention for this patient, at this point in his care, is intensive medical management, skilled nursing care, and intensive physical, occupational and often speech therapy, which inpatient rehabilitation facilities are accustomed to providing. He may well be denied admission based on his diagnosis, and the complement of other diagnoses treated in that facility that year, if 50% of the patients had similar diagnoses he would likely be denied, because the quota of 60% must be maintained for appropriate classification for the facility. No on-site observer would deny that this

facility was functioning as a rehabilitation hospital. And the outcome of this and similar patients are monitored and reported regularly from IRFs.

So what alternative criteria might be used to determine IRF classification? It appears that in our "75% rule" discussion for the last several years, we have been focusing on characteristics of a patient, especially diagnosis, to determine that the facility is in fact an acute rehabilitation hospital or unit. Other characteristics of the facility itself, such as degree of physician care, nursing staffing, intensity and breadth of rehabilitation services, would serve to accurately characterize the facility.

The disagreement about patient characteristics to be served in such a facility is really a question of individual patient "medical necessity;" that is, a difference of opinion about the appropriate setting for care. I would suggest that we try to clearly separate these issues going forward.

Alternative criteria, if we cannot separate the medical necessity issue, would be some measures of functional impairments, and medical needs, rather than diagnosis.

The third question raised has two distinct parts. Certainly other diagnoses should be included, such as malignancy, and cardiopulmonary disease. We see many such patients year after year with these diagnoses, who improve significantly, and are afforded a better quality of life.

But the second part of the question, cost-benefit, should not be overlooked. There is confusion, and some disagreement, about the relative costs and benefits to patients who receive some rehabilitation services in different sites. The only way to really explore this question is to require consistent description and measurements of patients' relevant characteristics at admission and discharge from all sites that deliver rehabilitation services as the primary need of the patient. Such measures should extend for a suitable period of time, the "episode of care" concept to add more information. Then the Medicare dollars expended and the patients' outcome for an "episode of care" could be more accurately assessed, and compared among differing sites.

Studies from our hospital and local freestanding nursing homes with subacute units (*Walsh, M.B., Herbold, J. (2005): Outcome after rehabilitation for total joint replacement at IRF and SNF, a case-controlled comparison. Am.J.Phy.Med.Rehabil 85:1*) find that a patient with a single hip or knee replacement or hip fracture, matched for age, severity, time from surgery, and locomotion FIM on admission stays about 20 days in the subacute unit, has twice the chance of becoming ill enough to require transfer back to an acute care hospital, and is significantly more likely to be discharged homebound, with ambulation only with a walker. In our hospital, her average stay is about 10 days, and significantly more likely to be a community ambulatory, not requiring home care. We are compiling actual Medicare payments for the 60 day episode of care, beginning with the date of surgery; preliminary findings are that the dollars spent by Medicare are quite similar.

However it is known, and frequently commented on in the relevant literature, that there is considerably more variation in SNFs than in the relatively homogenous IRFs, which makes these comparative effectiveness studies difficult, and often the results do not generalize beyond the specific sites studied.

Thank you for the opportunity to comment, and working together, I am confident we can devise a truly cost-effective system that focuses on each individual patient's need. As our society ages, and new diseases and treatments develop, we must focus on helping each person achieve their goals of maximal independent functioning, while being careful stewards of limited resources.

Sincerely,

Mary Beth Walsh, M.D.
Executive Medical Director/CEO