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

Dear Dr. Stankivic,

I am responding to requests for responses regarding the 75% rule for rehabilitation hospitals. As the Clinical Director of a large stroke rehabilitation program, I have generally not been subject to restriction of patients from admission to my center as a result of this rule. Thus, if anyone benefits from this rule, I do.

However, From my viewpoint, this is extremely unjust and unfair for the multitude of patients with other disabling disorders who are essentially excluded from rehabilitation because of the rule. This includes other disorders proven to benefit from intensive inpatient rehabilitation, for which evidence exists of the deleterious effects (greater rehospitalizations and poorer outcomes) of receiving rehabilitation services in less intensive environments. Please see the letter to you by Dr. John King, President of the Association of Academic Physiatrists, with which I wholeheartedly agree.

The 75% rule was established to help HHS differentiate acute care from exempt rehabilitation hospitals. In the 20+ years since it was proposed, medical care has changed and so has the spectrum of diseases helped by rehabilitation hospitals and units. I strongly urge you to scrap the rule altogether, as a basis for judging whether a hospital can be paid as a rehabilitation provider, or should be paid under DRG's. Instead, admissions to rehabilitation hospitals should be based on medical necessity.

What constitutes legitimate medical necessity presents another set of problems, as that is currently interpreted by intermediaries inconsistently and sometimes capriciously, to the detriment of many institutions providing legitimate acute intensive rehabilitation care to patients. Medical necessity should be based on evidence where that is available, but also on patients fulfilling criteria that indicate that either (1) a hospital level of care is indicated combined with a physical disability, or (2) the overall complexity of disability for a patient requires admission to an inpatient rehabilitation hospital or unit. By complexity of disability, I mean looking at all aspects of disability, combining impairment from the acute problem with other preexisting or concurrent impairments that are likely to interfere with recovery. For stroke patients, the presence of aphasia, cognitive, or swallowing problems, or severe motor deficits should qualify as complex. For orthopedic patients, the presence of a preexisting hemiparesis or multi-joint arthritis or severe medical debility should qualify. It does not make sense to penalize a rehabilitation provider who admits and treats patients fitting either of these criteria. Thus, I am suggesting that you expand your definition of medical necessity. This is especially true for orthopedic patients.

Face it, most skilled nursing facilities cannot handle complex multiple disabilities, and they certainly cannot handle complex medical problems requiring daily physician monitoring. Neither acute care hospitals nor nursing facilities can duplicate what acute inpatient rehabilitation hospitals and units offer. The 75% rule has caused stress to

rehabilitation institutions and no longer serves the needs of patients with disabilities, instead it has led to exclusion of many patients from these institutions.

I hope that these comments are helpful. Please contact me if you wish to discuss or clarify any of these points further.

Sincerely,

Arthur M. Gershkoff, M.D.
Clinical Director, Stroke and Neurologic Diseases MossRehab Hospital 60 East Township Line Road Elkins Park, Pennsylvania 19027

Associate Professor
Department of Rehabilitation Medicine
Thomas Jefferson University School of Medicine