From: Metro Health Hospital Rehab
Grand Rapids, Michigan

1. whether Medicare beneficiaries have access to medically necessary rehabilitation services and any potential effect of the “75% rule” on their access to appropriate care?

a. The virtual extinction of single joints from acute rehab has made it more difficult for those who might otherwise qualify for inpatient rehab. Case managers are hesitant to make referrals because of the perceived barrier to care. Even though we have been able to over turn the denials of single joints at the QIC and ALJ levels, the experience has severely impacted our willingness to go through all of the denial levels for payment. We agree that most single joints can be served at home or the subacute level but those patients experiencing medical comorbidities and functional deficits are best served at the acute rehab level.

b. The 85 year old age category is an arbitrary number. Anyone past 70 is at a greater risk for complications and can benefit from rehabilitation.

c.There are many trauma patients who could benefit from rehab but are not falling in the present multiple trauma category. For example, multiple fractures with no other system involvement. Therefore the trauma category should be expanded to include all trauma patients within the 75% rule. Balancing case mix affects and limits access when we are close to the 60%, therefore we deny admission to those that may otherwise benefit.

2. whether alternative criteria or refinements to the 75% rule could be used to determine IRF classification, including patients’ functional status, diagnosis, co morbidities, or other attributes?

a. Please refer to a, b, and c above as the dynamics impact both question 1 and 2.

b. Times are such that people are living through catastrophic illness and becoming debilitated in the process. The medically fragile and complex patients require a level of expertise available at the IRF and should be included within the 75% rule.

c. Cardiac and pulmonary patients having had surgery and/or exacerbations should be included in the 75% rule.

3. whether IRF care is appropriate for certain other types of conditions which are commonly treated in IRFs, but are outside of the 13 conditions specified in the 75% rule? Are there differences in patient outcomes and costs when these cases are treated in different settings?

a. We have many antidotal cases in our own health care system that indicate some patients are better served at the IRF. For example, Mrs. A, who had a history of multiple comorbid conditions and had single joint replaced. She was transferred to a subacute setting but readmitted after 10 days with pneumonia, malnutrition and generally failing to thrive. She was admitted to IRF and returned home with her daughter after 6 days of our comprehensive program with no further re-hospitalizations. One can surmise that if she received the full compliment of rehab treatment of physician oversight, rehab nursing, physical therapy, occupational therapy and social work in her original course she could have avoided further complications and rehospitalization and could have been effectively discharged home.

b.Other cases have involved the medically complex or fragile patients having had a long hospital course should be given the chance to be admitted to the IRF under the 75% rule. Historically, patients have thrived and returned home within relatively shorter time frames then the sub acute programs boast. A decrease in acute care days would occur if proper medical management is available while the patient is undergoing rehab.