Thank you for holding the Open Door Forum and allowing written comments in advance related to Medicare classification criteria for Inpatient Rehabilitation Facilities. I am the System Director of Third Party Reimbursement for Catholic Health East. I am not a clinician so my comments will not be clinical in nature; my background is with Medicare cost reports and reimbursement regulations. I believe that limiting IRF classification based on the 13 criteria noted in the 75% rule is too restrictive of who should be treated in an IRF. My comments below are brief snippets from my research that I would like you to consider when formulating your report to Congress and any future rules impacting the classification of IRFs.

- UDS had submitted a comment letter to your proposed rule for FY 2009 IRF, which is available on their website. Although the topic of their comment was not included in the CMS proposed rule and therefore may have been disregarded by CMS, they made the comment anyway, and I feel it is a topic CMS should consider. UDS commented that CMS needs to promulgate clear medical necessity policies for IRF, within one document, to be used by both Providers and MACs in evaluating the medical necessity of an admission to an IRF. I would suggest that adherence to or adoption of these medical necessity policies as admission policies could play a part in classification criteria as an IRF, instead of the 13 criteria in the 75% rule.
- MACs with restrictive LCDs can run counter to or confuse CMS guidance in the industry. These LCDs should be reigned in by CMS in future IRF rulemaking or guidance.
- A GAO report noted that condition and functional status should be a consideration in choosing the appropriate level of care.
- Various sources define intensive rehabilitation care as the patient being capable of tolerating three hours of daily therapy. Acute level being of moderate intensity, 0.5 – 1.5 hours daily therapy. Sub-acute where the patient requires considerable amount of care day and night and can not tolerate the minimum amount of therapy.
- When evaluating data, CMS should ensure that the data used is from a period 2005 and after, since they began strict enforcement of the 75% rule. After this enforcement tightened IRFs began to restrict the types of patients they admitted to ensure compliance with the 75% rule.

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