Association of Academic Physiatrists

1106 N. Charles Street, Suite 201
Baltimore, MD 21201-5557 USA
Phone: 410-637-8300
Fax: 410-637-8399
Web site: www.physiatry.org

President
John C. King, MD
San Antonio, Texas

President-Elect
Kristjan T. Ragnarsson, MD
New York, New York

Past-President
John Whyte, MD, PhD
Philadelphia, Pennsylvania

Secretary
Jean E. Shelton, MD
Norfolk, Virginia

Treasurer
Michael L. Boninger, MD
Pittsburgh, Pennsylvania

Members At Large
Daniel M. Clinchot, MD (2007–2011)
Columbus, Ohio

Susan V. Garstang, MD (2007–2011)
Newark, New Jersey

Kevin M. Means, MD (2005–2009)
Little Rock, Arkansas

Jeffrey B. Palmer, MD (2007–2009)
Baltimore, Maryland

Lawrence R. Robinson, MD (2007–2011)
Seattle, Washington

Kathryn A. Stolp, MD (2005–2009)
Rochester, Minnesota

AAMC Representatives
Ralph M. Buschbacher, MD
Indianapolis, Indiana

Joel A. DeLisa, MD, MS
Newark, New Jersey

American Journal of PM&R Editor
Walter R. Frontera, MD, PhD
San Juan, Puerto Rico

AAP Newsletter Editor
Joseph J. Chen, MD
Iowa City, Iowa

Executive Director
Lawrence C. Pencak

Association of Academic Physiatrists

January 30, 2009

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

Re: Association of Academic Physiatrists Input for the Town Hall Meeting: Medicare Classification Criteria for Inpatient Rehabilitation Facilities

Dear Ms. Stankivic,

We appreciate the opportunity to provide input representing the academic physiatrists, those who teach and research the provision of comprehensive physical rehabilitation services at all levels of care.

The AAP understands that the initial purpose of the 75% rule was to help define inpatient rehabilitation hospitals and to distinguish them from acute care hospitals and SNFs, and not to decree what types of patients were appropriate rehabilitation candidates. The rule was not designed as a statement about what clinical disorders could benefit from inpatient rehabilitation. However, that is how it is used. The additional layer of requirements of the 75% rule only serves to restrict access and no longer serves the original purpose, which was to help distinguish inpatient rehabilitation facilities from DRG hospitals.

Studies indicate the detrimental effect of the rule on patient access. In "Medicare's New Restrictions on Rehabilitation Admissions" by Segal M, Pedersen AL, et al; (*American Journal of Physical Medicine & Rehabilitation* 2008; 87:872-882), this article (attached) directly addresses the impact of the imposition of the 75% rule, comparing those non-qualifying Rehabilitation Impairment Code diagnosed cohorts (N = 3893) in the first year of enforcement of this rule to the same cohorts (N = 4107) from the year prior. This study clearly demonstrates the harm of not providing comprehensive rehabilitation to those in need, caused by the regulatory requirements of the 75% Rule to restrict access due to diagnosis alone. Increased readmissions, which other studies have not considered in cost analyses, and worse, increased mortality, occurred in these otherwise similar groups. The mortality disparity increased from 25% to 54% in 85+ year olds with orthopaedic diagnoses, more than doubling the death rate. The only Rehabilitation Impairment Code that did not show significantly poorer health outcomes in the study was the large subgroups of miscellaneous and lower limb joint replacement/osteoarthritis.

The Rehabilitation Impairment Codes of Other Orthopaedic (RIC 09), Cardiac (RIC 14), Pulmonary (RIC 15), and Pain Syndromes (RIC 16) all are appropriate for comprehensive inpatient rehabilitation facility care to improve outcomes for Medicare beneficiaries.

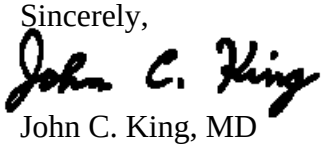
Moreover, certain patient sub-populations of the Miscellaneous group (RIC 20), such as Transplant patients, have been shown to benefit significantly by inpatient rehabilitation facility care which has not been as well studied in lesser care environments (Lin E, King JC, Sotello K: "Organ transplant versus other debilitated patients-- inpatient rehabilitation functional outcomes and payment recovery." *Archives of Physical Medicine and Rehabilitation*, 2004; 85: e20). Such patients often require very close, daily, or more frequent, medical supervision during the early post transplant period, which is when inpatient rehabilitation care is more likely to be needed. Skilled nursing facilities cannot provide this level of medical care and long term acute care hospitals are a more costly option that usually cannot provide as intense rehabilitation services as an inpatient rehabilitation facility.

Many things in the nature of health care have changed since the 75% rule was laid down. Many cardiac, pulmonary, pain, and transplant patients could not have been included in the initial development of the 75% rule as these types of patients did not exist in the late 1970's when the 75% rule was defined. In these patients it is not the diagnoses but the patient's functional status and medical complexity that define the need for inpatient rehabilitation facility care. This is what our field trains medical specialists to do; to identify the appropriate levels, safety monitoring and interventions needed to enhance each individual's function and quality of life as optimally as possible.

To answer the inquiries Congress has mandated:

(1) Medicare beneficiaries do not always have access to medically necessary rehabilitation services. The 75% rule restricts many appropriate Medicare beneficiaries' access to IRF level of care and thereby increases mortality and hospital readmissions.
(2) The 75% rule is not necessary and does not serve to define or distinguish inpatient rehabilitation facilities beyond the requirements embedded in the prospective payment system for inpatient rehabilitation facilities. If it must be retained for other purposes, it needs to be revised to add the appropriate RIC diagnoses of RICs 09, 14, 15, 16 and Transplant patients from RIC 20.
(3) RIC diagnoses from RICs 09, 14, 15, 16 and Transplant patients from RIC 20 all have been shown to have improved outcomes with IRF care making this the most appropriate level of care for these Medicare beneficiaries.

Sincerely,



John C. King, MD
President, Association of Academic Physiatrists