RE: Special Open Door Forum – Medicare Classification Criteria for Inpatient Rehabilitation Facilities (IRF)

Introduction

The Idaho Elks Rehabilitation Hospital is a 61 bed not-for-profit hospital in Boise, Idaho. Its core program is rehabilitation which began 60 years ago as the community's response to polio. The hospital has a 46 bed inpatient rehabilitation unit (IRF) and a 15 bed skill nursing facility (SNF). We appreciate the opportunity to provide input at this open door forum and look forward to the delivery system improvements for rehabilitation patients that may result from this study.

Though we plan to provide unique input from our point of view, we would like to begin by acknowledging the written report that was submitted to you by Dr. Bruce Gans for AMRPA on February 2, 2009. We are AMRPA members and believe its report covers the major issues from the rehabilitation industry's point of view.

We are submitting this report form the point of view of a long term rehabilitation not for profit hospital to provide additional insights to the issues and to emphasize how important rehabilitation is to future patients in our community.

Fundamental definition of Physical Rehabilitation

Inpatient physical rehabilitation is a comprehensive therapeutic program that provides people who experience a significant loss in physical function, from a traumatic or medical incident, the opportunity to regain their maximum level of independence in order to return to their most productive role in society. It is in society's interest that comprehensive rehabilitation achieves the maximum functional ability for patients in the most cost effective and efficient manner possible. Therefore, the focus of the rehabilitation delivery system should be on patient outcomes that benefits society.

The best way to determine the rehabilitation need of a rehabilitation inpatient is to do an assessment that measures the patient's functional ability at the time of admission. A patient's medical status and comorbidities are also pertinent to assessing a patient's rehabilitation program needs; however, the essence of a rehabilitation program is the level of a patient's functional ability and their potential for recovery. Following the assessment of the patient, the comprehensive rehabilitation evaluation process should include a forecast of how the patient may benefit functionally from the rehabilitation treatment. In other words, at time of discharge what functional improvements are expected to occur due to the rehabilitation program? The gap between the functional ability of the patient at admission and the forecasted functional ability of the patient at discharge explains the reason for the rehabilitation treatment and determines the benefit of the rehabilitation episode to the patient and society. It is this improvement in the patient's physical function and the patient's enhanced role in society that justifies the cost of the rehabilitation services provided. The goal of the Centers for Medicare and Medicaid Services (CMS) should be to develop regulations for rehabilitation programs that ensure providers demonstrate an ability to assess a patient's function at admission, to forecast beneficial rehabilitation and medical outcomes and to measure the extent to which the provider is able to deliver the beneficial outcomes forecasted. The level of reimbursement for rehabilitation services should be consistent with the reasonable cost to obtain the desired rehabilitation patient outcomes.

The Benefit of Rehabilitation to Society

The benefit of rehabilitation services to society is that it decreases the burden of expensive aftercare when patients obtain a level of independence that allows them to return home vs. institutional care. Institutional care is often paid for by a combination of Federal and State funding that is diminished when rehabilitation patients learn to remain independent at home. Therefore, comprehensive rehabilitation services can be cost effective and benefit both patients and society.

The 75% rule limits patient access to IRF level rehabilitation

The 60% rule, formerly the 75% rule, limits access to the comprehensive inpatient rehabilitation services offered by an IRF. Many Medicare patients may not access an IRF because admissions are limited to certain diagnoses and because of the narrow interpretation of the Medicare patient

criteria for the IRF setting. Diagnosis is an inappropriate criteria for admission to an IRF because it is the functional ability of a patient at admission and the potential of recovery of the patient's functional ability that determines if rehabilitation treatment if justified - not the diagnosis of the patient.

CMS has not yet developed rehabilitation criteria and regulations that capture the essential differences of the post acute care rehabilitation providers they certify. CMS reports that there is often not sufficient clinical evidence to justify the cost differences among the different post acute care settings or to justify different payments for the rehabilitation treatments provided by the different settings.

Unfortunately, the more costly IRF setting is under attack by CMS and post treatment denials have the IRF industry in a state of significant disarray. Access to IRF care is being insidiously and severely limited by the industry's inability to create a stable provider environment for its patients and staff. IRF setting are finding it more and more difficult to hire and retain doctors and rehabilitation professions required to provide IRF level care. Instead of caring for rehabilitation patients, Medical Directors and staff are spending time appealing denials and trying to explain to insurance companies and patients families just who may be admitted to the IRF setting and why. Medical judgment has been replaced by restrictive and confusing criteria.

So as the industry struggles to justify what it does, more and more professionals have simply given up and moved into alternative treatment setting that are more stable. The current ambiguity surrounding the IRF admission criteria is killing the IRF industry and will certainly limited future Medicare patients' access to the comprehensive rehabilitation services if this situation does not improve soon.

IRF vs. SNF Rehabilitation

The industry is in significant transition and the level of rehabilitation services offered by IRFs and SNFs is not very distinct. Economic conditions and vague admission criteria are pushing insurance companies, including those representing Medicare, to deny the IRF rehabilitation treatment alternative even when a patient meets the admission criteria. Insurance companies are

simply insisting on SNF level rehabilitation services to save money regardless of patient needs or outcomes. To meet patients needs and today's economic realities our hospital is providing IRF level services in its SNF at a significant financial loss to the hospital. This practice is not unique; other rehabilitation hospitals are also providing higher level of rehabilitation services in their hospital based SNF. Continuing this practice will cause IRFs to close for economic reasons thus further limiting patient access to the rehabilitation services provided by IRF and IRFs with SNF beds. See item 6 below for a possible solution for this issue.

If we need to keep the foundation of the current system and are looking for ways to improve the current system please consider the following items:

1. Add diagnoses

If CMS decides to stay with the current concept of limiting access to IRFs through diagnostic admission criteria, then the list of diagnoses should be expanded to include
any patient who experiences a significant loss in physical function, from a traumatic or medical incident, who has the potential to regain their independence through a comprehensive rehabilitation program in a reasonable period of time. Additional diagnostic criteria should include cardiac patients, pulmonary patients, cancer patients, orthopedic, and medical patients who have lost their functional ability due to an extensive period of immobility from a serious illness.

2. Consider changing the interpretation of the 3 hour rule and its relationship to the concept of intensively of a rehabilitation episode

A current Medicare criterion CMS uses to indicate the intensity of the rehabilitation process is that inpatients require 3 hours of therapy 5 of 7 days a week in an IRF. However, it is not the number of hours of therapy that indicates the intensity of a rehabilitation program. Rather, it is the comprehensive nature of the services available to a patient that determines the intensity of service that may be provided. The therapies referenced in the 3 hour rule include physical therapy, occupational therapy and speech pathology. Though important, they are not the only important rehabilitation services provided by a comprehensive rehabilitation program. A more enlightened view of rehabilitation understands that it is the comprehensive nature of a rehabilitation program that explains the difference between less intense and more intense

rehabilitation program. The services of social workers, psychologists, prosthetists, orthotists, respiratory therapists, vocational counselors, and driver training instructors could be more important to the full recovery of a patient than the designated therapies in the Medicare 3 hour rule criterion. A long list of comprehensive rehabilitation services must be available for a rehabilitation program to deliver the intensity of services required by rehabilitation patients and therefore, the list of available services required to meet the need of patients should be the preferred measured of intensity.

3. More on the concept of intensity of rehabilitation and the 3 hour rule

The current Medicare regulations support a concept that an IRF's should only treat inpatients that require intense rehabilitation. This concept has been somewhat distorted over time by those interpreting the regulations to include the number of therapy hours provided each day to the patient in a rehabilitation program. Not all rehabilitation inpatients benefit from a therapy schedule of three hours of therapy. Some patients may recover nicely with less than three hours of therapy a day on some days and more than three hours of therapy on other days. The current interpretation of the 3 hour rule for an IRF is too narrow and does not encourage optimization of therapy treatment hours to maximize patient outcomes and optimize cost. An average number of hours of therapy over an extended period of time should be considered to replace the current 3 hour rule. An example of this enhanced interpretation of the rule may be that IRF patients must average 15 hours of therapy or more in a seven day period.

4. Medical Necessity – the medical needs of patients

A second IRF intensity criterion that is misunderstood by some regulators is the concept of medical necessity. The medical necessity criterion for an IRF is sometimes incorrectly interpreted to mean that an IRF patient must require intense acute medical services during their IRF stay in order to meet Medicare's medical necessity criterion. This is an incorrect understanding of IRF patient's medical requirements. When a patient is admitted to an IRF, his/her medical issues must be stable enough for the patient to participate in their rehabilitation program.

An IRF is a specialty service that is directed by doctors trained in the specialty of rehabilitation. The rehabilitation medicine doctor attends to rehabilitation inpatients medical needs while in the

IRF and directs the patients' rehabilitation program. On admission, most rehabilitation patients are medically fragile after their short acute care hospital stay. The rehabilitation doctor assesses the patients' medical condition, requests medical consults and maintains patients in an appropriate medical condition so the patient may fully participate in their rehabilitation program.

It is the daily medical direction of the attending rehabilitation doctor available 24 hours a day that keeps medically fragile patients stable enough for rehabilitation services. The doctor prescribes the medical and rehabilitation services required by the patient and monitors that the rehabilitation objectives are met. It is this combination of medical services that explains the unique medical requirement of rehabilitation patients and is the more appropriate interpretation of what medical necessity means for an IRF patient. The concept that IRF patients must constantly receive intense acute medical services to remain in an IRF rehabilitation program is incorrect. The fact that the patient was recently medically fragile and could return to a seriously compromised medical condition if not followed by the IRF attending doctor is the criteria that should be used to meet the definition of the medical necessity criterion for an IRF.

5. Medical Necessity - Rehabilitation Nursing

A third component of medical necessity is the requirement for rehabilitation nursing services at an IRF. IRF nurses implement unique rehabilitation nursing protocols to maximize the independence of patients in the shortest time possible. The rehabilitation nurses care for patients 24 hours a day, 7 days a week and it is their attention and direction that teaches the patient how to implement and follow through with the rehabilitation instructions they received in rehabilitation treatments during their stay. The level of nursing is an important component of medical necessity. The more rehabilitation nursing is a patient requirement, the more the patient should meet the CMS medical necessity criterion.

6. IRFs can and should be allowed to provide SNF rehabilitation level services

IRFs can efficiently and effectively provide all levels of rehabilitation and should have the option to provide SNF level rehabilitation at a just rate determined by Medicare until clinical evidence justifies a more appropriate alternative.

IRF providers have a long history of treating rehabilitation patients across the continuum of care. It does this by matching the patient needs to the proper mix of rehabilitation services required by patients. An example of this is phenomenon is explained by understanding the course of treatment for a typical stroke patient. A stroke patient may require significant medical services from an acute care hospital to properly diagnose and treat the stroke patient's acute medical condition. Once the patient stabilizes medically, the patient may be transferred to an IRF for comprehensive services to regain the ability to walk, to swallow, and to recover their independence in activities of daily living. After an IRF discharge to home, the patient may return to the rehabilitation hospital for outpatient services to continue working on speech and comprehension skills and to safely re-learn driving skills. In this case, the patient's condition appropriately determines the types and level of rehabilitation services the patient receives.

Most people who are knowledgeable about rehabilitation agree that an IRF may cost effectively provide both inpatient and outpatient rehabilitation services. This suggests that IRF resources may be used effectively at different levels of care for rehabilitation patients along the continuum of care. However, this is not currently true for IRF and SNF rehabilitation levels of care.

IRFs have, in the past and should in the future, be able to provide SNF level rehabilitation services to rehabilitation patients. The issue of proper reimbursement of IRFs for what CMS believes is SNF level care simply needs to be resolved by CMS as quickly as possible. Once resolved, IRF resources may be fully utilized to more cost effectively care for rehabilitation inpatients. IRF providers who do not wish to care for the SNF plus level rehabilitation patients may opt out of this line of rehabilitation care if they wish to do so. Resolving the more intense level of rehabilitation versus the less intense level of rehabilitation issue, will encourage appropriate providers to compete for the privilege of providing rehabilitation services to patients who require them in the most cost effective manner possible.

The Opportunity; Rehabilitation the Continuum of Care Alternative

Physical Rehabilitation is provided in inpatient setting following an episode at an acute care hospital. Post acute care inpatient rehabilitation services may be provided in a number of different Medicare certified inpatient settings including a Skilled Nursing Facility (SNF), an Inpatient Rehabilitation Facility (IRF), and Long Term Acute Care Hospital (LTCH).

CMS is working on the development of “The Care Tool” to assess patients across the continuum of care and this new assessment tool has the potential of resolving the problem of not having a common functional assessment tool across the post acute care continuum.

A significant challenge for the current health care delivery system is the cost effective delivery of rehabilitation care. The current post acute care delivery system is expensive and has considerable overlap due to unrelated certification criteria. The post acute delivery system is a disconnected collection of silos all doing what the ill conceived regulations require them to do to stay operational, but this does not meet the needs of patients. The needs of patients should be driving the system.

The future post acute care rehabilitation care delivery system should require providers to assess the needs of patients at admission and at discharge to determine if the prescribed rehabilitation program benefits patients. CMS should only consider paying for rehabilitation services, over the long run, to the extent that the rehabilitation services deliver the desired patient rehabilitation outcomes in the most cost effective manner possible.

CMS should establish a rehabilitation care delivery system that classifies patients by their medical and rehabilitation conditions and then encourages rehabilitation providers to offer their services to the patient for the fee determined by CMS to be appropriate. Initially, there should be some consideration for the added cost the current system providers incur because of the current regulations. However, as the Care Tool evolves and the ability of data collection tools correctly classifies rehabilitation patients, unique certification requirements that justify additional reimbursement should be eliminated.

Eventually, post acute care providers should be classified by the type and level of services they provide. In this enhanced rehabilitation system, it would be appropriate for rehabilitation providers to provide more than one level of rehabilitation care. A fully integrated rehabilitation provider could provide the appropriate level of rehabilitation care, from inpatient to outpatient services, by matching their comprehensive rehabilitation services to the exact need of patients.

This would result in the creation of the most cost effective rehabilitation care delivery system possible.

In the short term, Medicare has developed a SNF plus program for hip and knee patients which should be implemented immediately to improve access to services for patients, and to improve access to rehabilitation patients for IRF's. Resolving these issues could also redirect the work of RACS to more productive uses. Clinical evidence should continue to be collected and ongoing adjustments to the care delivery system be implemented when appropriate and supported by the clinical evidence.

Thank you for the opportunity to provide input to this most important project.

Sincerely,

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