Hello, my name is Jim Peaker and I am the Director of a 15 bed acute rehab unit in rural northern California. We face some interested challenges being the only rehab in a 120 mile radius, serving a population of just under 200,000. As a physical therapist in our rehab for the last 10+ years, and now the Director the past year, I have certainly seen the impact of changing regulations regarding admission criteria. The 75% rule is certainly a contributing factor, although it is primarily the issues with audits and denials plaguing the acute rehab community which has curtailed our ability to provide service to those who would benefit from acute rehab stays.

In response to the three questions posed – the following summarizes each question and my feedback:

(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?* The modifications to the rule permanently changing the level to 60% have lessened the accessibility issues of our patients based on diagnoses. A larger issue is the interpretation of "medically necessary rehabilitation services" by our fiscal intermediary. Their distortion of this criteria has placed undue burden on the acute rehab community in general and our facility specifically. Our facility is facing serious survivability issues due to these restrictions. Our census is one half of what is was 10 years ago - this can in part be attributed to medical advances and criteria clarifications, but many patients whom referring physicians and our medical director feel require acute rehabilitation are unable to be accepted based on the unrealistic interpretation of this definition by the fiscal intermediary auditors. Our unit is in process of appealing a probe audit by our fiscal intermediary, and although the experts reassure us that the majority of our denials will be overturned, surviving this lengthy process and the burdensome time and cost may affect our ability to remain open.

(2) *whether alternative criteria or refinements to the 75% rule could be used to determine IRF classification, including patients' functional status, diagnosis, comorbidities, or other attributes?* Having any sort of classification criteria attempts to pigeonhole a medical model of which no one has a crystal ball as to ultimate patient outcome, and therefore appropriateness for an acute rehab stay. Based on the exhaustive look at the 75% rule and modification made for the final rule, this flawed system may be our best option for the near future. As stated earlier, it is the yoke if the fiscal intermediary audits which binds our hands at this point. In an ideal world, a look at outcomes (functional as well as return home and long-term health) would be a better way to judge admission criteria.

(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?*. As alluded to in question 2, having a way to look beyond the limitations of diagnosis-based criteria to an outcomes based criteria would permit the physician to actually coordinate care based on the patient's best interest. In looking at outcomes, I also oversee a busy outpatient therapy clinic and collaborate closely with our home health agencies. We also do follow up calls to rehab patients 1 week and 100 days after discharge. Anecdotally, looking at outcomes for our patients and receiving feedback from both home health and outpatient, speed of recovery and quality of life are significantly positively affected by a rehab stay. I would welcome and participate in any long term study of these factors based on diagnosis and outcomes for patients admitted to acute rehab versus those discharged to other settings. I definitely believe a study of long term costs would bear out the effectiveness of acute rehab when compared to alternative discharge settings.

Thank you for the opportunity to provide my input in regards to this issue. It is certainly difficult to provide ironclad criteria to a process to the art of medicine. I would welcome the opportunity to offer additional insights or assistance if appropriate.

Sincerely,

Jim Peaker, PT

Director of Rehabilitation Services
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