As a physician in the practice of PM&R for over 20 years and the Vice-president of Medical Services for Allied Services in Northeastern Pennsylvania, I appreciate the opportunity to comment on these topics of the 75% rule and medical necessity in the rehab setting. As a specialist in rehabilitation the first concern is the functional status of a patient. Blending in other factors, such as, medical condition,social concerns, home environment, help complete the picture in determining the best course of action in treating a patient. This includes the level of care. Consequently, I would hope CMS would view a patient in the manner a physiatrist does.

The primary concern would be functional status and potential to improve. This would take the emphasis off the diagnosis as the determinant for a rehab hospital. This contrasts with the 75% rule under which patients lose access. Should an 80 year old Medicare patient with multiple co-morbidities be denied access to an appropriate rehab hospital setting because she had a knee replacement rather than a hip fracture? The practice of Rehabilitation Medicine speaks strongly against such an approach. However, this loss of access is the reality and was echoed in sentiments expressed during the Open Door Forum.

The consideration should be to have a functionally based determination. CMS, with access to outcome data demonstrating functional improvements, could readily make a assessment that a facility was working to rehabilitate patients. If necessary, JCAHO, CARF, or Medicare surveyors could provide on-site confirmation that the facility is engaged in rehabilitation.

Regarding the issue of medical necessity, I would express the feeling of everyone I have spoken to in the field that clarity be brought to the process. Medicare has put forth the elements required to meet medical necessity for in-patient rehabilitation. However, they are general to the point that an auditor can arbitrarily state that a patient did not meet the medical necessity requirement. As multiple providers expressed, they expend considerable time and expense to defend their position of having admitted a patient. Ultimately, many denials are overturned. With greater involvement of the RACs it will be more lost resources.

There is extreme frustration among providers that provide high quality rehabilitation in-patient services with excellent outcomes. They expend their resources in these efforts only to have retrospective denials based on non-specific criteria. This can be rectified with better agreement between the providers and CMS prior to admission.

I would fervently ask that a pre-admission process be instituted to clear this situation. For example, the Medicare criteria for admission would contain a matrix that defines more precisely what constitutes a rehabilitation in-patient. A panel of experts would develop for each diagnostic category more specific criteria that takes into account functional status, medical condition,social, and environmental issues. So, a total knee replacement patient with no comorbidities and functioning at a supervision level would not meet the criteria, however, a total knee patient with multiple comorbidities and functioning at a minimum to moderate level would meet medical necessity.

Further refinement would be to assign a "rehab score" (again a combination of functional, medical, and social variables) for these patients based on the matrix. The score would answer the medical necessity issue. Much of the ambiguity could be removed and a great deal of time and money would be saved. Medicare patients would have access to the appropriate level of care.

Thank you for your consideration of these comments. I would be willing to participate in any efforts that would facilitate the implementation of the suggested actions.

Sincerely,
Gregory Basting, MD
Fellow of the American Academy of Physical Medicine and Rehabilitation