RE: Medicare Classification Criteria for Inpatient Rehabilitation Facilities

Given the current economic climate and the question of future solvency I believe that collectively we understand the need for enhanced control of CMS's expenses. It is recognized that the enforcement of the 75% rule in 2004 has garnered the desired effects. However, we need to proceed with caution to insure that the beneficiaries of Medicare will have continued access to the appropriate acute inpatient rehabilitation services they require.

Twenty years ago HCFA asked the American Academy of Physician Medicine and Rehabilitation to identify the etiologic diagnoses of patients routinely admitted to inpatient rehabilitation programs. A subcommittee was convened and the original list of ten conditions was developed through a simple brainstorming method. There was no research or scientific methodology applied to this process.

In the interim the advancements in cardiology, pulmonology, oncology and organ transplantation have contributed to a dramatically changed health care environment. The patients presenting for admission consideration today would probably not have survived back then. These are people who have significant and very real functional impairments that warrant admission into a comprehensive inpatient rehabilitation program so that they may return as productive members of their communities.

The challenges facing the future of the inpatient rehabilitation industry is immense. The industry met the challenge of gradual compliance with the 75% Rule. With the Medicare, Medicaid and SCHIP Extension Act of 2007 the industry received welcomed relief only then to undergo increasing external scrutiny by various agencies and entities empowered by CMS to retrospectively identify and collect what they perceive to be over payments.

As rehabilitation providers we strive to improve patients' function through the provision of patient-centered, outcome focused care by an integrated interdisciplinary rehabilitation process. The current structure of the 75% Rule and inconsistent application of loosely worded appropriateness criteria in the RAC audit process are presenting significant barriers, both human and financial. I would encourage CMS to consider the following options:

Develop clear regulatory standards for *each post-acute level of rehabilitation care* to include the expected services to be delivered, the required attributes of physical plant, the patient care process and data collection systems.
Discard the 75% Rule diagnoses list and replace it with guidelines that enable the IRH/U to address and treat both the medical and functional needs of the patients. The current diagnostic criterion does not sufficiently reflect the true needs or value of the program to the patients.
Provide supplemental guidelines that allow the rehabilitation provider to consider function, complications and co-morbidities when evaluating potential admissions in the event that CMS is unwilling or unable to discard the 75% Rule.
Expand the diagnoses list to include at minimum cancer, cardiac, pulmonary and transplant patients in the event that CMS is unwilling or unable to discard the 75% Rule.
Develop objective medical necessity criteria with the input from a variety of stakeholders. This panel of experts would work concurrently and collaboratively with CMS to regularly review and update the criteria. Providers would understand and utilize appropriately the criteria they will be measured against and auditors would receive uniform training in the consistent application of the criteria.
Conduct ongoing research into the efficacy and efficiency of each level of rehabilitative care with future policy decisions being evidence-based and data driven.
Publish accurate data/information to promote transparence from providers to consumers.

Financial resources are in short supply on both sides of the equation. We need to collaborate to develop clear expectations that could all but eliminate the need for an auditing process that penalizes providers for services already provided. We can then put our financial resources to work caring for those we serve. Collectively, we are dedicated to do what is best for the beneficiaries within the constraints with which we are faced.

I thank you for this opportunity to provide input into this challenging topic.

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