Julie M. Stankivic – Health Insurance Specialist – Centers for Medicare and Medicaid Services

Dear Ms. Stankivic:

My name is Cris Huerta. I am the VP of Clinical Services – Rehab Division with Senior Care, Inc. located in Louisville, KY. Our corporation operates 3 inpatient freestanding rehab hospitals in 3 different states. I have over 20 years experience in the physical rehab field and over 25 years as a Registered Nurse and CRRN.
Please allow me first to thank you for the opportunity to submit my observations and comments related to the 3 stated objectives which RTI is evaluating. I participated in the conference call held on February 2, 2009. I was quite pleased to see the rehab industry so well represented by those who were present and those who submitted commentary. I most certainly applaud those comments and believe they spoke for the larger, al beit silent, majority.

In discussion with our 3 hospital CEO's, we submit the following for your additional consideration:

- The Rule has most certainly had an effect on Medicare beneficiaries accessing appropriate care. The use of a limited listing of medical diagnosis automatically disregards the needs of many others outside of the confined 13 diagnosis. Physician and case management decision-makers are often pressed for time in making discharge placement decisions. The application of such complex criteria often lead to rehab-appropriate patients being placed in less than optimal settings, due to these time constraints. A functional based set of criteria would more appropriately identify those patients whose condition is most likely to benefit from an inpatient admission. A functional based language is one that would transcend all service areas; therefore, ensuring access and appropriate placement decisions by medical staff.
- In the absence of such a criteria; allow consideration of the following for extension of the diagnosis listing to include: Cardiac, Pulmonary, Organ Transplant and ESRD (Renal) patients. These conditions are often associated with significant loss of function and present a greater risk of complication when care settings are not adequately prepared to provide the intensive medical coverage and therapeutic services provided in an acute rehab setting.
- In further defining the determination of IRF classifications, the comment offered by Brian Boone, President - CARF related to an accreditation model for this purpose, holds some promise. By accrediting the provider, the guessing game is eliminated and the determination of appropriate rehab admissions is at the discretion of qualified care providers.

Thank you for this opportunity,

Cris Huerta, RN, CRRN, MBA-HCM
VP Clinical Operations