

- The comorbidity has caused significant functional ability decline in the individual such that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities paid under subpart P of this part and which cannot be appropriately performed in another care setting covered under this title.

We are also proposing a new § 412.23(b)(2)(ii) that specifies for cost reporting periods beginning on or after January 1, 2007, the hospital has served an inpatient population of whom at least 75 percent required intensive rehabilitative services for treatment of one or more of the conditions specified at paragraph (b)(2)(iii) of this section.

In proposed § 412.23(b)(2)(iii), we are proposing to retain the existing conditions except for polyarthritides, which we are proposing to replace with the following three new conditions:

- Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living, which has not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or which results from a systemic disease activation immediately before admission, but has the potential to improve with more intensive rehabilitation.

- Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living, which has not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or which results from a systemic disease activation immediately before admission, but has the potential to improve with more intensive rehabilitation.

- Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving three or more major joints (elbow, shoulders, hips, or knees) with joint deformity and substantial loss of range of motion, atrophy, significant functional impairment of ambulation and other activities of daily living, which has not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately

preceding the inpatient rehabilitation admission but has the potential to improve with more intensive rehabilitation. (A joint replaced by a prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)

Furthermore, in section II.C., we are proposing the possible use of comorbidities to verify compliance with proposed § 412.23(b)(2).

We are also proposing to phase-out the reduction from 75 percent to 65 percent and the use of comorbidities to verify compliance, as discussed in section II.D., on January 1, 2007 with the intention of using data acquired and analysis performed during this period to revise the rule, if necessary, prior to the phase-out date. Lastly, in section II.E., we are proposing to change the time period used to determine compliance with the proposed 65 percent rule.

A. Change of the Percentage of the Inpatient Population

Under proposed § 412.23(b)(2)(i), we are proposing, starting with the effective date of the final rule and subject to the proposed phase-out provision discussed in section II.D., to change the percentage of the total IRF patient population used as a criterion to distinguish an IRF from an acute care hospital from 75 percent to 65 percent.

We recognize that rehabilitation practice may have changed since we developed the original list of conditions. We are, however, concerned that in some cases, patients may have been transferred inappropriately from the inpatient setting and, thus, these inappropriate responses may be responsible for some of these changes in rehabilitation practice rather than medical advances.

We believe that the list of medical conditions we are proposing in this rule identifies patients who typically can benefit from the type of intensive inpatient rehabilitation services provided by IRFs. We do, however, recognize that there may be certain atypical patients admitted for other conditions who may be appropriate for care in an IRF. As a precaution to mitigate any unintended effects on access to care while we perform the analysis discussed in section II.D., we are proposing to lower the percentage of cases to 65 percent. We welcome the development and presentation of objective evidence that shows the type of patients most appropriately treated in the IRF setting, compared to other settings.

As reflected in both the present and now proposed policies, we do not

believe it is necessary that an IRF must treat patients only with the medical conditions listed in proposed § 412.23(b)(2)(iii) to distinguish it from other inpatient settings as an inpatient hospital setting that is primarily engaged in furnishing intensive rehabilitation services. Patients may have a variety of medical conditions that require rehabilitation treatment and the rehabilitation treatment may be furnished by a variety of rehabilitation programs. However, while an IRF is one of the settings that is available to furnish rehabilitation, it may not be the most appropriate setting to treat a medical condition not listed in proposed § 412.23(b)(2)(iii).

Patients with the medical conditions not listed in proposed § 412.23(b)(2)(iii) have always had, and will continue to have, rehabilitation programs in IRFs and other settings available to them that we believe can furnish the type of treatment that is commensurate to the need they have for rehabilitation. While being a prudent purchaser of health care services for Medicare beneficiaries is an important factor, the most important determination is which rehabilitation program is the most appropriate in relation to the patient's medical condition and rehabilitation needs, that is, the rehabilitation services furnished by the most appropriate rehabilitation program.

Although the previous analysis of impairment group and diagnoses data from the IRF-PAI suggests that IRFs are treating a patient population with more than 35 percent of cases with medical conditions other than those specified in proposed § 412.23(b)(2)(iii), this does not in and of itself provide evidence that the IRF is the most appropriate rehabilitation treatment modality for these patients. We welcome evidence or studies demonstrating that patients with medical conditions not included in proposed § 412.23(b)(2)(iii) generally require intensive inpatient rehabilitation and have better outcomes compared to other settings.

Although there may have been "medical advances" in rehabilitation or at least changes in practice patterns since the medical conditions listed at proposed § 412.23(b)(2)(iii) were developed, it is not clear that there is evidence supporting a clinical basis for these changes. Instead, in some cases, patients may have been transferred inappropriately from the inpatient setting which may have played a major role in changing practice patterns and in deciding which patients are admitted to IRFs. We note that the general trend has been the migration of care from the acute inpatient hospital setting to