

inpatient rehabilitation setting provided in an IRF. Although it has been asserted that patients at risk for thrombosis, pressure ulcers, or infections should be treated in IRFs, all hip and knee joint replacement patients are at risk for those conditions. Likewise the presence of comorbidities such as diabetes and hypertension are common conditions that can generally be managed in the outpatient setting. We believe that there have been strong reimbursement incentives to send patients to IRFs and that these considerations have influenced the choice of setting for patients' care. We welcome data or studies that might provide evidence about whether certain patients had better outcomes as a result of care in IRFs.

We are also aware of proposals from the public that Medicare should count cases with lower functional status in RICs for joint replacement, cardiac, osteoarthritis, and pulmonary as cases that meet proposed § 412.23(b)(2)(iii). We are not proposing such a policy because the lower score of function on admission does not generally reflect a need for intensive inpatient rehabilitation services for patients with these medical conditions. Some patients may improve without rehabilitation, and others may not have the capability to improve even with rehabilitation.

We believe other conditions listed in proposed § 412.23(b)(2)(iii) also need to be clarified. The categories of brain and spinal cord injuries could appropriately be defined to include neoplasms of the brain, spinal cord, or meninges that result in substantial functional deficits as non-traumatic brain injuries and non-traumatic spinal cord injuries, since the course of rehabilitation for these conditions is very similar to the rehabilitation for other brain or spinal cord injuries. Although patients presenting with these conditions are currently paid under RIC 20, we believe that these patients can be counted towards the categories of cases listed in proposed § 412.23(b)(2)(iii) and invite comments of our interpretation.

Another category described in proposed § 412.23(b)(2)(iii) that requires clarification is major multiple trauma. Our contractors have noticed that some patients with relatively minor injuries at times are counted as having this condition. To clarify which patients should be counted, the IRF can determine if the acute care hospital service for a patient at the time of the initial injury was identified by diagnosis-related groups 484, 485, 486, or 487. We recognize that not all patients whose acute hospitalization was classified into DRG 484, 485, 486,

or 487 will be admitted to an IRF immediately after the injury, because some may require a period of recuperation and healing before beginning the intensive inpatient rehabilitation care. We are soliciting comments regarding this methodology.

C. Proposal To Consider Using a Comorbidity To Verify Compliance

In this section of the proposed rule, we discuss the possible use of comorbidities to verify compliance with proposed § 412.23(b)(2)(i). Under the IRF PPS, we defined a comorbidity at § 412.602 as a specific patient condition that is secondary to the patient's principal diagnosis that is the primary reason for the inpatient rehabilitation stay.

Section II.C.1 below describes a proposed methodology in which cases other than those admitted with a principal diagnosis matching one or more of the 12 conditions specified in proposed § 412.23(b)(2)(iii) could be considered to satisfy the proposed 65 percent rule if certain additional criteria are met. Section II.C.2 below describes another alternative, in which a case that has a comorbidity that matches one of the conditions in proposed § 412.23(b)(2)(iii) could be considered to satisfy the proposed 65 percent rule only if the patient is admitted to an IRF for postoperative care immediately following a hip or knee replacement. We are soliciting comments on both of these proposed methodologies.

1. Proposed Methodology

Under proposed § 412.23(b)(2)(i), we are proposing that starting with the effective date of the final rule and subject to the proposed phase-out provision discussed in section II.D., a case with a principal diagnosis that does not match one of the proposed 12 conditions be considered as meeting proposed § 412.23(b)(2)(i) if *all* of the following criteria are met: (1) The patient is admitted for rehabilitation for a condition that is not one of the conditions listed in proposed § 412.23(b)(2)(iii); (2) The patient also has a comorbidity that falls in one of the conditions listed in proposed § 412.23(b)(2)(iii); and (3) 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 intensive rehabilitation treatment that is unique to inpatient rehabilitation facilities and which cannot be appropriately performed in another setting, such as inpatient hospital, skilled nursing

facility, home health, or outpatient setting.

The following explanation provides guidance regarding classifying the proposed "arthritis-related" conditions as comorbidities which may be counted as complying with proposed § 412.23(b)(2)(i). If the comorbidity is active, polyarticular rheumatoid arthritis, psoriatic arthritis, seronegative arthropathies, or systemic vasculidities with joint replacement, the patient must have undergone an appropriate, aggressive, and sustained course of outpatient therapy immediately preceding the inpatient rehabilitation or have experienced a systemic disease activation immediately before admission in order for the admission to be included in cases complying with proposed § 412.23(b)(2)(i). If the comorbidity is severe or advanced osteoarthritis involving three or more joints, the patient must have undergone an appropriate, aggressive, and sustained course of outpatient therapy immediately preceding the inpatient rehabilitation in order for the admission to be included in cases complying with proposed § 412.23(b)(2)(i).

The following provides clinical examples of diagnoses which indicate when a comorbidity would and would not be considered in determining compliance with the proposed 65 percent rule. These examples are for illustrative purposes only and are not meant to be the only scenarios where comorbidities would or would not be considered in determining compliance with the proposed 65 percent rule. Furthermore, these examples are not intended to represent, define, or establish clinical criteria for benefit coverage determinations.

Examples of Clinical Scenarios That Are Likely To Be Included Under This Policy

(1) A patient who has severe arthritis in both shoulders and in his right knee has his left hip replaced with a non-cemented total hip prosthesis. Although before his joint replacement, he received an aggressive and sustained course of outpatient physical and occupational therapy, at the time of discharge from the acute care hospital, he still has considerable atrophy and weakness in his right quadriceps and hamstring muscles such that he is unable to support his entire weight on his right lower limb. He also has very restricted forward flexion in his right shoulder so that he is limited to 15 degrees of forward flexion. He has severe pain with weight-bearing through his upper limbs in both shoulders. Since after surgery, he can only have partial weight-bearing on his left lower limb, he requires