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Innovations Influencing Physical Medicine and Rehabilitation

The Transformation of the Rehabilitation Paradigm Across the Continuum of Care

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Abstract

As healthcare continues to evolve, there are changes in the delivery of care for patients with severe neurologic injuries. Although the acute hospital stay is shortening, physiatrists can play a key role in preparing patients for rehabilitation, minimizing longer-term complications and helping to determine the most appropriate paths for further treatment. Inpatient rehabilitation facilities (IRFs) continue to be an important part of the care continuum for patients with severe injuries, but the role of IRFs has also evolved as patients have been admitted with increasing medical and neurologic complexity and length of stay continues to be reduced. Skilled nursing facilities and subacute facilities continue to evolve, in part to fill the gaps that have developed for patients who are "not yet ready for rehabilitation" and for those whose recovery trajectory has been deemed too slow for IRF. Outpatient care is also changing, in part due to the availability of new rehabilitation interventions as highlighted in other sections of the supplement. Furthermore, telemedicine will provide additional options for expanding specialized care beyond prior geographical limitations. Physiatrists need to be aware of these ongoing changes and the roles that they can play outside of the traditional IRF model of care. This article will focus on the innovations in healthcare delivery and opportunities to maximize outcomes in the current and future models of care.

Introduction (How Did We Get Here and Where Are We Going)

The Health Care Financing Administration (HCFA) was created to administer Medicare and Medicaid in 1977. A year later HCFA requested assistance from the American Academy of Physical Medicine and Rehabilitation (AAPMR) and other organizations to identify criteria for inpatient rehabilitation facilities or units that would distinguish them from medical-surgical units. The AAPM&R's Rehabilitation Criteria Committee for the Professional Standards Review Organization hospital review system was chaired by Dr Leon Reinstein along with seven other Academy members. The Committee identified and presented 3 criteria for admission to a rehabilitation facility (IRF) or unit: medical stability to participate in rehabilitation; reasonable expectation that the patient would experience significant functional improvement in a reasonable period of time; and the patient was expected and able to tolerate and participate in 3 hours of daily therapy [1,2].

The Committee also identified the 10 most common inpatient rehabilitation diagnoses that would characterize the population of an IRF. The following diagnoses were selected: stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, fracture of the femur, brain injury, polyarthritis, neurologic disorders, and burns.

The initial estimate of the cost to Medicare for the provision of healthcare was rapidly exceeded and, in an attempt to bring costs under control, HCFA created the Prospective Payment System, based on Diagnostic Related Groups (PPS-DRG) in 1985. This system would replace the previously implemented per-diem payment system with a lump sum for each diagnosis, based on national data. Thus, if a hospital discharged the patient earlier than the national average, the hospital would make money. However, if the patient's length of stay at the hospital was longer than the national average, the hospital would lose money. Importantly, Medicare exempted the fields of pediatrics, psychiatry, and physical medicine and rehabilitation (PM&R) from

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PPS-DRG. Pediatrics was exempted because there were, of course, few pediatric patients on Medicare. Psychiatry and PM&R were exempted because they did not strictly follow medical-surgical inpatient care models. The impact of exempting inpatient rehabilitation from PPS-DRG was significant. The majority of the acute care hospitals in the country wanted a small inpatient rehabilitation unit so that they could move quickly acute medical-surgical patients out of acute care to a PPS-DRG exempt inpatient rehabilitation unit and manage their acute care length of stay. The number of acute inpatient rehabilitation beds more than doubled in a 5-year period to 33,000 and grew to 41,000 by 2000. The number of IRFs grew in the same 15-year period from 450 to 1048 [3].

To differentiate an exempt inpatient rehabilitation unit/hospital from a medical/surgical unit, HCFA took the original 1978 list of the 10 most common inpatient rehabilitation diagnoses and created the "75% Rule." The intention was that in each fiscal year, 75% of the patients in an inpatient rehabilitation facility had one of the 10 most common inpatient rehabilitation diagnoses. The list became known as the "HCFA-10."

The number of IRF discharges increased by a factor of 6 from 69,000 in 1985 to 411,000 in 2000. During this time, the 75% Rule was not enforced. By 2000, Medicare annual total expenses exceeded $220 billion. More importantly, total rehabilitation expenses were almost $8 billion, ranking number 11 among Medicare expenses by diagnosis. HCFA had now become the Centers for Medicare and Medicaid Services (CMS). CMS sprang into action and began enforcing the 75% Rule. IRFs that did not meet the 75% rule were decertified as IRFs by CMS. The field of PM&R attempted to explain to CMS that the list of 10 diagnoses was more than 20 years old and no longer relevant. Medical and surgical advances had made tremendous strides in the past 22 years. IRFs were caring for many complex medical-surgical patients who truly needed IRF-level care but were not on the HCFA-10 List, including cardiac or pulmonary postsurgical patients (eg, status post left ventricular assist device, coronary valve replacement), or lung, heart, or liver transplant who had significant functional limitations. In response to those concerns, on May 19, 2003, CMS convened a meeting and a year later, CMS issued its Final Rule regarding IRFs. The 75% Rule would continue to be enforced and would be phased in over the course of 4 years. On July 1, 2004, the percentage applied would be 50% and each subsequent July 1, the percentage would increase until it reached 75% on July 1, 2008. Also, beginning on July 2004, total joint replacements would only be counted toward the HCFA-10 if the patient had bilateral joint replacements, if the patient was extremely obese with a body mass index $>$50, or was 85 years of age or older [4]. The impact of enforcement of the 75% Rule was a rapid reduction in the number of IRF beds, which decreased by 7% in 2006 and to 38,000 in 2008. The number of IRF discharges went from 510,000 in 2004 to 412,000 by 2006 [5].

The rehabilitation community sought relief from the U.S. Congress and on December 29, 2007, President George W. Bush signed a law that froze the 75% Rule at 60%. In 2009, CMS issued "New Coverage Policies for Inpatient Rehabilitation Services" [4]. These policies identified additional requirements including physician documentation of preadmission screening and postadmission evaluations, eliminated the 3- to 10-day rehabilitation trial period, and required that an interdisciplinary plan of care be completed within 4 days of a patient's admission to the IRF among other changes. In June 2014, the Medicare Payment Advisory Commission (MedPAC) issued a report to the U.S. Congress titled "Site-Neutral Payments for Select Conditions Treated in Inpatient Rehabilitation Facilities and Skilled Nursing Facilities." Their argument was that the CMS should not pay more for care in one setting than in another setting if the care can safely and effectively be provided in the lower cost setting. MedPAC further recommended: "For the site-neutral conditions, CMS could consider waiving requirements such as requiring that patients are able to tolerate and benefit from an intensive therapy program (often demonstrated by furnishing three hours of therapy a day) and receive frequent physician supervision (often satisfied by physician face-to-face visits at least three days a week)" [6].

It is surprising that MedPAC would consider proposing that IRFs "function more like SNFs [skilled nursing facilities]" when MedPAC's own data shows that, in 2011, 71% of patients in IRFs were discharged to the community compared with 28% of patients in SNFs. Additionally, 19% of patients in SNFs were readmitted to an acute hospital within 30 days of acute discharge to an SNF compared with only 12% of IRF patients in an IRF [7]. The first decade of the 21st century saw Medicare more than doubling spending for post-acute care services from $27 billion in 2001 to $59 billion in 2016 [8].

In 2013, Medicare total spending exceeded $600 billion, and it is projected that by 2020 will exceed $1 trillion; with such a high cost who needs acute, inpatient rehabilitation [9]. Can care be moved to other settings and provide effective outcomes in a more efficient manner?

Rehabilitation in the Acute Hospital and IRF Setting

The role of physiatrists in the acute care setting varies greatly by site of care, practice, and even among physicians in the same group. There are many reasons for this variation. Some physiatrists may not be as knowledgeable about acute care methods and interventions and may not be comfortable actively participating in the clinical management of medically complex patients. The involvement of physiatrists in clinical decision-making may not be as welcomed in

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