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MEDICARE

More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities

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June 16, 2005

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Highlights

Highlights of GAO-05-825T, a report before the Subcommittee on Health, Committee on Ways and Means, House of Representatives

Why GAO Did This Study

Medicare classifies inpatient rehabilitation facilities (IRF) using the "75 percent rule." If a facility can show that during a 12-month period at least 75 percent of its patients required intensive rehabilitation for 1 of 13 listed conditions, it may be classified as an IRF and paid at a higher rate than for less intensive rehabilitation in other settings. Because this difference can be substantial, it is important to classify IRFs correctly. GAO was asked to discuss issues relating to the classification of IRFs, and in April 2005 it issued a report, *Medicare: More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities* (GAO-05-366). For that report, GAO analyzed data on all Medicare patients (the majority of patients in IRFs) admitted to IRFs in fiscal year 2003, spoke to IRF medical directors, and had the Institute of Medicine (IOM) convene a meeting of experts to evaluate the use of a list of conditions in the 75 percent rule. This testimony is based on the April 2005 report.

What GAO Recommends

In its April 2005 report, GAO recommended that CMS take several actions, including describing more thoroughly the subgroups of patients within a condition that require IRF services, possibly using functional status or other factors in addition to condition. CMS generally agreed with the recommendations.

www.gao.gov/cgi-bin/getrpt?GAO-05-825T.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Marjorie Kanof at (202) 512-7114.

What GAO Found

As noted in the April 2005 report, GAO found that in fiscal year 2003 fewer than half of all IRF Medicare patients were admitted for having a primary condition on the list in the 75 percent rule. Almost half of all patients with conditions not on the list were admitted for orthopedic conditions, and among those the largest group was joint replacement patients. The experts IOM convened said that uncomplicated unilateral joint replacement patients rarely need to be admitted to an IRF, and GAO analysis suggested that relatively few of the Medicare unilateral joint replacement patients had comorbid conditions that suggested a possible need for the IRF level of services. Additionally, GAO found that only 6 percent of IRFs in fiscal year 2003 were able to meet a 75 percent threshold.

GAO also found that IRFs varied in the criteria used to assess patients for admission, using patient characteristics such as functional status, as well as condition. The Centers for Medicare & Medicaid Services (CMS), working through its fiscal intermediaries, had not routinely reviewed IRF admission decisions to determine whether they were medically justified, although it reported that such reviews could be used to target problem areas.

The experts IOM convened and other clinical and nonclinical experts GAO interviewed differed on whether conditions should be added to the list in the 75 percent rule. The experts IOM convened questioned the strength of the evidence for adding conditions to the list—finding the evidence for certain orthopedic conditions particularly weak—and some of them reported that little information was available on the need for inpatient rehabilitation for cardiac, transplant, pulmonary, or oncology patients. They called for further research to identify the types of patients that need inpatient rehabilitation and to understand the effectiveness of IRFs. There was general agreement among all the groups of experts interviewed that condition alone is insufficient for identifying appropriate types of patients for inpatient rehabilitation, since within any condition only a subgroup of patients require the level of services of an IRF, and that functional status should also be considered in addition to condition.

GAO concluded that if condition alone is not sufficient for determining which types of patients are most appropriate for IRFs, more conditions should not be added to the list at the present time and the rule should be refined to clarify which types of patients should be in IRFs as opposed to another setting.

Madam Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss our report entitled *Medicare: More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities*,[1] which was issued in April 2005. Over the past decade, both the number of inpatient rehabilitation facilities (IRF)[2] and Medicare payments to these facilities have grown steadily. In 2003, there were about 1,200 such facilities. Medicare payments to IRFs grew from $2.8 billion in 1992 to an estimated $5.7 billion 2003 and are projected to grow to almost $9 billion per year by 2015.

Because patients treated at IRFs require more intensive rehabilitation than is provided in other settings, such as an acute care hospital or a skilled nursing facility (SNF),[3] Medicare pays for treatment at an IRF at a higher rate than it pays for treatment in other settings. The difference in payment to IRFs and other settings can be substantial, and so IRFs need to be correctly classified to be distinguished from other settings in which less intensive rehabilitation is provided.

To distinguish IRFs from other settings for payment purposes and to ensure that Medicare patients needing less intensive services are not in IRFs, the Centers for Medicare & Medicaid Services (CMS) relies on a regulation commonly known as the "75 percent rule."[4] This rule states that if a facility can show that during a 12-month period at least 75 percent of all its patients, including its Medicare patients, required intensive rehabilitation services for the treatment of at least 1 of the 13 conditions listed in the rule,[5] it may be classified as an IRF. The rule allows the

[1]See GAO, *Medicare: More Specific Criteria Needed to Classify Inpatient Rehabilitation Facilities*, GAO-05-366 (Washington, D.C.: Apr. 22, 2005).

[2]IRFs are intended to serve patients recovering from medical conditions that require an intensive level of rehabilitation. Not all patients with a given condition may require the level of rehabilitation provided in an IRF. For example, although a subset of patients who have had a stroke may require the intensive level of care provided by an IRF, others may be less severely disabled and require less intensive services.

[3]In addition to IRFs, acute care hospitals, and SNFs, other settings that provide rehabilitation services include long-term-care hospitals, outpatient rehabilitation facilities, and home health care.

[4]*See* 42 U.S.C. §1395ww(d)(1)(B) (2000). The 75 percent rule was initially issued in 1983 and most recently revised in 2004. *See* 42 C.F.R. §412.23(b)(2) (2004).

[5]For an annotated list of these conditions, see appendix I.

remaining 25 percent of patients to have other conditions not listed in the rule. IRFs are required to assess patients prior to admission to ensure they require the level of services provided in an IRF, and CMS is responsible for evaluating the appropriateness of individual admissions after the patient has been discharged through reviews for medical necessity conducted under contract by its fiscal intermediaries.[6] An IRF that does not comply with the requirements of the 75 percent rule may lose its classification as an IRF and therefore no longer be eligible for payment by Medicare at a higher rate.[7]

IRF compliance with the rule has been problematic, and some IRFs have questioned the requirements of the rule. CMS data indicate that in 2002 only 13 percent of IRFs had at least 75 percent of patients in 1 of the 10 conditions on the list at that time. IRF officials have contended that the list of conditions in the rule should be updated because of changes in medicine that have occurred and the concomitant expansion of the population that could benefit from inpatient rehabilitation services.

The Conference Report that accompanied the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 directed us to issue a report, in consultation with experts in the field of physical medicine and rehabilitation, to assess whether the current list of conditions represents a clinically appropriate standard for defining IRF services and, if not, to determine which additional conditions should be added to the list.[8] In this testimony, I will discuss our April 2005 report, in which we (1) identified the conditions—on and off the list—that IRF Medicare patients have and the number of IRFs that meet the requirements of the 75 percent rule; (2) described how IRFs assess patients for admission and whether CMS reviews admission decisions; and (3) evaluated the approach of using a list of conditions in the 75 percent rule to classify IRFs.

[6]Fiscal intermediaries are contractors to CMS that verify compliance with the rule and conduct reviews for medical necessity to determine whether an individual admission to an IRF is covered under Medicare.

[7]In addition to the 75 percent rule, an IRF must meet six regulatory criteria showing that it had (1) a Medicare provider agreement; (2) a preadmission screening procedure; (3) medical, nursing, and therapy services; (4) a plan of treatment for each patient; (5) a coordinated multidisciplinary team approach; and (6) a medical director of rehabilitation with specified training or experience. IRFs must also meet other criteria identified in 42 C.F.R. §412.22 (2004) and 42 C.F.R. §412.25 (2004).

[8]See H.R. Rep. 108-391, at 649 (2003).

In carrying out our work, we analyzed data from the Inpatient Rehabilitation Facility—Patient Assessment Instrument (IRF-PAI) records on all Medicare patients (the majority of patients in IRFs) admitted to IRFs in fiscal year 2003[9] (the most recent data available at the time). The IRF-PAI records contain, for each Medicare patient, the impairment group code[10] identifying the patient's primary condition and the diagnostic code from the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) identifying the patient's comorbid condition (if any).[11] We used these codes to determine whether we considered the patient's primary or comorbid condition to be linked to a condition on the list in the rule.[12] We also spoke to 12 IRF medical directors, 10 fiscal intermediary officials, and contracted with the Institute of Medicine (IOM) of the National Academies to convene a 1-day meeting of 14 clinical experts in physical medicine and rehabilitation to evaluate the approach of using a list of conditions in the 75 percent rule. We conducted our work from May 2004 through April 2005 in accordance with generally accepted government auditing standards.

In brief, as noted in the report, in fiscal year 2003 fewer than half of all IRF Medicare patients were admitted for having a primary condition on the list in the 75 percent rule. Almost half of all patients with conditions not on the list were admitted for orthopedic conditions, and among those the largest group was joint replacement patients. The experts IOM convened told us that uncomplicated unilateral joint replacement patients rarely need to be admitted to an IRF, and our analysis suggested that relatively

[9]We analyzed the 2003 data using the 13 conditions in the current regulation even though in fiscal year 2003 there were 10 conditions on the list. Effective July 1, 2004, the number of conditions increased from 10 to 13.

[10]The impairment group code identifies the medical condition that caused the patient to be admitted to an IRF, and its sole function is to determine payment rates. As a result, the impairment group codes describe every patient in an IRF and include medical conditions that are on the list in the rule as well as those that are not on the list since IRFs may treat patients with conditions not on the list. In contrast, the list of conditions in the rule describes the patient population that is to be treated in an IRF to ensure that a facility is appropriately classified to justify payment for the level of services furnished.

[11]As used in this report, a primary condition is the first or foremost medical condition for which the patient was admitted to an IRF, and other medical conditions may coexist in the patient as comorbid conditions, or comorbidities.

[12]Throughout this testimony, the "list in the rule" refers to the list of 13 conditions as specified in the 2004 75 percent rule, and when we say that condition is on (or off) the list, we mean that we have (or have not) been able to link the condition as identified in the patient assessment record to a condition on the list in the rule.

few of the Medicare unilateral joint replacement patients had comorbid conditions that suggested a possible need for the IRF level of services. Additionally, we found that only 6 percent of IRFs in fiscal year 2003 were able to meet a 75 percent threshold. We also found that IRFs varied in the criteria used to assess patients for admission, using patient characteristics such as functional status, as well as condition. We noted that CMS, working through its fiscal intermediaries, had not routinely reviewed IRF admission decisions to determine whether they were medically justified, although it reported that such reviews could be used to target problem areas. The experts IOM convened and other clinical and nonclinical experts we interviewed differed on whether conditions should be added to the list in the 75 percent rule. The experts IOM convened questioned the strength of the evidence for adding conditions to the list—finding the evidence for certain orthopedic conditions particularly weak—and some of them reported that little information was available on the need for inpatient rehabilitation for cardiac, transplant, pulmonary, or oncology patients. They called for further research to identify the types of patients that need inpatient rehabilitation and to understand the effectiveness of IRFs. There was general agreement among all the groups of experts we interviewed that condition alone is insufficient for identifying appropriate types of patients for inpatient rehabilitation, since within any condition only a subgroup of patients require the level of services of an IRF, and that functional status should also be considered in addition to condition.

We concluded that if condition alone is not sufficient for determining which types of patients are most appropriate for IRFs, more conditions should not be added to the list at the present time and the rule should be refined to clarify which types of patients should be in IRFs as opposed to another setting. As noted in the report, we recommended that CMS ensure that targeted reviews for medical necessity are conducted for IRF admissions; conduct additional activities to encourage research on IRFs; and refine the 75 percent rule to more clearly describe the subgroups of patients within a condition that are appropriate for IRFs, possibly using functional status or other factors in addition to condition. CMS generally agreed with our recommendations.

Background

The 75 percent rule was established in 1983 to distinguish IRFs from other facilities for payment purposes. According to CMS, the conditions on the list in the rule at that time accounted for 75 percent of the admissions to IRFs. In June 2002 CMS suspended the enforcement of the 75 percent rule after its study of the fiscal intermediaries revealed that they were using inconsistent methods to determine whether an IRF was in compliance and

that in some cases IRFs were not being reviewed for compliance at all. CMS standardized the verification process that the fiscal intermediaries were to use, and issued a rule—effective July 1, 2004—that increased the number of conditions from 10 to 13 and provided a 3-year transition period, ending in July 2007, to phase in the 75 percent threshold.[13]

The current payment and review procedures for IRFs were established in recent years. The inpatient rehabilitation facility prospective payment system (IRF PPS) was implemented in January 2002. Payment is contingent on an IRF's completing the IRF-PAI after admission and transmitting the resulting data to CMS. Two basic requirements must be met if inpatient hospital stays for rehabilitation services are to be covered: (1) the services must be reasonable and necessary, and (2) it must be reasonable and necessary to furnish the care on an inpatient hospital basis, rather than in a less intensive facility, such as a SNF, or on an outpatient basis.[14] Determinations of whether hospital stays for rehabilitation services are reasonable and necessary must be based on an assessment of each beneficiary's individual care needs. Beginning in April 2002, the fiscal intermediaries, the entities that conduct compliance reviews, were specifically authorized to conduct reviews for medical necessity to determine whether an individual admission to an IRF was covered under Medicare.[15]

[13]During the transition period, the threshold increases each year (from 50 percent to 60 percent to 65 percent) before the 75 percent threshold is effective. The transition period also allows a patient to be counted toward the required threshold if the patient is admitted for either a primary or comorbid condition on the list in the rule. At the end of the transition period, a patient cannot be counted toward the required threshold on the basis of a comorbidity on the list in the rule.

[14]Rehabilitative care in a hospital, rather than a SNF or on an outpatient basis, is considered to be reasonable and necessary when a patient requires a more coordinated, intensive program of multiple services than is generally found outside of a hospital (*Medicare Benefit Policy Manual*, chapter 1, Section 110.1).

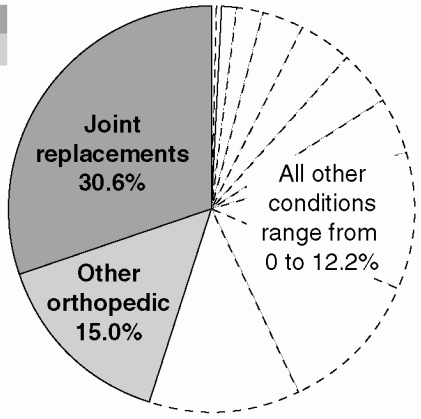
[15]Prior to this time, Quality Improvement Organizations had this authority. CMS Transmittal 21 made clear that fiscal intermediaries have the authority to review admissions to IRFs.

Fewer Than Half of All IRF Medicare Patients in 2003 Were Admitted for Conditions on List in Rule, and Few IRFs Were Able to Meet a 75 Percent Threshold

As we reported in April 2005, among the 506,662 Medicare patients admitted to an IRF in fiscal year 2003, less than 44 percent were admitted with a primary condition on the list in the 75 percent rule. About another 18 percent of IRF Medicare patients were admitted with a comorbid condition that was on the list in the rule. Among the 194,922 IRF Medicare patients that did not have a primary or comorbid condition on the list in the rule, almost half were admitted for orthopedic conditions, and among those the largest group was joint replacement patients whose condition did not meet the list's specific criteria. (See figure 1.)

Figure 1: Distribution of IRF Medicare Patients Who Did Not Have Condition on List in Rule, by Condition as Defined by Impairment Group, Fiscal Year 2003

Conditions, as defined by impairment group	Number of patients who did not have primary or comorbid condition on list in rule	Percentage of total patients who did not have primary or comorbid condition on list in rule
Joint replacements[a]	59,638	30.6
Other orthopedic conditions	29,191	15.0
Cardiac	23,715	12.2
Medically complex	22,785	11.7
Debility	21,424	11.0
Pain syndromes	8,847	4.5
Pulmonary disorders	8,616	4.4
Arthritis	8,321	4.3
Neurologic conditions	6,576	3.4
Other disabling impairments	4,145	2.1
Brain dysfunction	848	0.4
Amputation	796	0.4
Developmental disability	20	0
Total	**194,922**	**100.0**



Source: GAO analysis of CMS IRF-PAI data.

[a]Includes joint replacement patients who had a unilateral procedure and those who were under age 85 and therefore did not meet two of the three specific criteria for joint replacements set out in the 75 percent rule. (See app. I.) Codes from CMS for the third criterion—body mass index—were not available.

Although some joint replacement patients may need admission to an IRF, such as those with comorbidities that affect the patient's function, our analysis showed that few of these patients had comorbidities that suggested a possible need for the level of services offered by an IRF. Our analysis found that 87 percent of joint replacement patients admitted to IRFs in fiscal year 2003 did not meet the criteria of the rule, and among those, over 84 percent did not have any comorbidities that would have affected the costs of their care based on our analysis of the payment data.

Because the data we analyzed were from 2003, when enforcement of the rule was suspended, we also looked at newly released data from July through December 2004, after enforcement had resumed, to determine whether admission patterns had changed. We focused on the largest category of patients admitted to IRFs, joint replacement patients, and

found no material change in the admission of joint replacement patients for the same time periods in 2003 and 2004. Across all IRFs, the percentage of Medicare patients admitted for a joint replacement declined by 0.1 percentage point.

In conjunction with our finding on the number of patients admitted to IRFs for conditions not on the list in the rule, we determined that only 6 percent of IRFs in fiscal year 2003 were able to meet a 75 percent threshold. Many IRFs were able to meet the lower thresholds that would be in place early in the transition period, but progressively fewer IRFs were able to meet the higher threshold levels.

IRFs Vary in the Criteria Used to Assess Patients for Admission, and CMS Does Not Routinely Review IRFs' Admission Decisions

As we stated in our report, the criteria IRFs used to assess patients for admission varied by facility and included patient characteristics in addition to condition. All the IRF officials we interviewed evaluated a patient's function when assessing whether a patient needed the level of services of an IRF. Whereas some IRF officials reported that they used function to characterize patients who were appropriate for admission (e.g., patients with a potential for functional improvement), others said they used function to characterize patients not appropriate for admission (e.g., patients whose functional level was too high, indicating that they could go home, or too low, indicating that they needed to be in a SNF). Almost half of the IRF officials interviewed stated that function was the main factor that should be considered in assessing the need for IRF services.

IRF officials reported to us that they did not admit all the patients they assessed. Typically, the IRF received a request from a physician in the acute care hospital requesting a medical consultation from an IRF physician, or from a hospital discharge planner or social worker indicating that they had a potential patient. An IRF staff member—usually a physician and/or a nurse—conducted an assessment prior to admission to determine whether to admit a patient.

CMS, working through its fiscal intermediaries, has not routinely reviewed IRF admission decisions, although it reported that such reviews could be used to target problem areas. Among the 10 fiscal intermediary officials we interviewed, over half were not conducting reviews of patients admitted to IRFs. We concluded that the presence of patients in IRFs who may not need the intense level of services provided by IRFs called for increased scrutiny of IRF admissions, which could target problem areas and vulnerabilities and thereby reduce the number of inappropriate admissions

in the future. We recommended that CMS ensure that its fiscal intermediaries routinely conduct targeted reviews for medical necessity for IRF admissions. CMS agreed that targeted reviews are necessary and said that it expected its contractors to direct their resources toward areas of risk. It also reported that it has expanded its efforts to provide greater oversight of IRF admissions through local policies that have been implemented or are being developed by the fiscal intermediaries.

Experts Differed on Adding Conditions to List in Rule but Agreed That Condition Alone Does Not Provide Sufficient Criteria

As we reported, the experts IOM convened and other experts we interviewed differed on whether conditions should be added to the list in the 75 percent rule but agreed that condition alone does not provide sufficient criteria to identify types of patients appropriate for IRFs.

The experts IOM convened generally questioned the strength of the evidence for adding conditions to the list in the rule. They reported that the evidence on the benefits of IRF services is variable, particularly for certain orthopedic conditions, and some of them reported that little information was available on the need for inpatient rehabilitation for cardiac, transplant, pulmonary, or oncology conditions. In general, they reported that, except for a few subpopulations, uncomplicated, unilateral joint replacement patients rarely need to be admitted to an IRF. Most of them called for further research to identify the types of patients that need inpatient rehabilitation and to understand the effectiveness of IRFs in comparison with other settings of care. IRF officials we interviewed did not agree on whether conditions, including a broader category of joint replacements, should be added to the list in the rule. Half of them suggested that joint replacement be more broadly defined to include more patients saying, for example, that the current requirements were too restrictive and arbitrary. Others said that unilateral joint replacement patients were not generally appropriate for IRFs. We recommended that CMS conduct additional activities to encourage research on the effectiveness of intensive inpatient rehabilitation and factors that predict patient need for these services. CMS agreed and said that it has expanded its activities to guide future research efforts by encouraging government research organizations, academic institutions, and the rehabilitation industry to conduct both general and targeted research, and plans to collaborate with the National Institutes of Health to determine how to best promote research.

There was general agreement among all the groups of experts we interviewed, including the experts IOM convened, that condition alone is insufficient for identifying appropriate types of patients for inpatient

rehabilitation, because not all patients with a condition on the list need to be in an IRF. For example, stroke is on the list, but not all stroke patients need to go to an IRF after their hospitalization. Similarly, cardiac condition is not on the list, but some cardiac patients may need to be admitted to an IRF. Among the experts convened by IOM, functional status was identified most frequently as the information required in addition to condition. Half of them commented on the need to add information about functional status, such as functional need, functional decline, motor and cognitive function, and functional disability. However, some of the experts convened by IOM recognized the challenge of operationalizing a measure of function, and some experts questioned the ability of the current assessment tools to predict which types of patients will improve if treated in an IRF.[16]

We concluded that if condition alone is not sufficient for determining which types of patients are most appropriate for IRFs, more conditions should not be added to the list at the present time, and that future efforts should refine the rule to increase its clarity about which types of patients are most appropriate for IRFs. We recommended that CMS use the information obtained from reviews for medical necessity, research activities, and other sources to refine the rule to describe more thoroughly the subgroups of patients within a condition that require IRF services, possibly using functional status or other factors, in addition to condition. CMS stated that while it expected to follow our recommendation, it would need to give this action careful consideration because it could result in a more restrictive policy than the present regulations, and noted that future research could guide the agency's description of subgroups.

Concluding Observations

As we stated in our report, we believe that action to conduct reviews for medical necessity and to produce more information about the effectiveness of inpatient rehabilitation could support future efforts to refine the rule over time to increase its clarity about which types of patients are most appropriate for IRFs. These actions could help to ensure that Medicare does not pay IRFs for patients who could be treated in a less intensive setting and does not misclassify facilities for payment.

[16]For example, one fiscal intermediary official reported that the instrument that is currently used does not adequately measure progress in small increments, such as a quadriplegic patient might experience. Another respondent also reported that the current instrument only measures functional status at a point in time, but does not predict functional improvement.

Madam Chairman, this concludes my prepared statement. I would be happy to respond to any questions you or other Members of the Subcommittee may have at this time.

Contact and Staff Acknowledgments

For further information about this testimony, please contact Marjorie Kanof at (202) 512-7114. Linda Kohn and Roseanne Price also made key contributions to this statement.

Appendix I: List of Conditions in CMS's 75 Percent Rule

A facility may be classified as an IRF if it can show that, during a 12-month period[1] at least 75 percent of all its patients, including its Medicare patients, required intensive rehabilitation services for the treatment of one or more of the following conditions:[2]

1. Stroke.
2. Spinal cord injury.
3. Congenital deformity.
4. Amputation.
5. Major multiple trauma.
6. Fracture of femur (hip fracture).
7. Brain injury.
8. Neurological disorders (including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease).
9. Burns.
10. Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have 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 that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.
11. Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive

[1]The time period is defined by CMS or the CMS contractor.

[2]*See* 42 C.F.R. §412.23(b)(2)(iii) (2004).

rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

12. Severe or advanced osteoarthritis (osteoarthritis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after the patient has participated in 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 have 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.)

13. Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay and also meet one or more of the following specific criteria:

    a. The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.

    b. The patient is extremely obese, with a body mass index of at least 50 at the time of admission to the IRF.

    c. The patient is age 85 or older at the time of admission to the IRF.

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