

STANDARDS FOR
ASSESSING
MEDICAL APPROPRIATENESS
CRITERIA FOR ADMITTING
PATIENTS TO
REHABILITATION HOSPITALS
OR UNITS

Prepared by:
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Standards for Assessing Medical Appropriateness Criteria for Admitting Patients to Rehabilitation Hospitals or Units

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Standards for Assessing Medical Appropriateness Criteria for Admitting Patients to Rehabilitation Hospitals or Units

I. Introduction

The decision to admit a patient to a hospital is the responsibility of a physician and a primary function of the practice of medicine. In many cases, that decision is self-evident, for example when the patient has a life-threatening illness or injury. However, often the medical decision to admit a patient to a rehabilitation hospital or unit (referred to as an Inpatient Rehabilitation Facility (IRF) by the Medicare program) is more complex and involves the consideration of medical, functional and other criteria that are almost always inter-related.

Disagreements over the decision to admit a patient are commonly encountered with insurance carriers, regulators, and governmental agencies. There are few evidence-based standards that physicians or hospitals can look to defend their clinical judgments.

Many hospitals have formal admitting criteria. Many insurers, agencies, and regulatory bodies have attempted to create admitting decision tools or criteria (such as the Local Coverage Determinations of Medicare, elements of the Medicare 75% Rule, and private organizations' products such as InterQual's Level of Care tool). The lack of agreement between many of these criteria and prevailing clinical practice is striking, and forms the basis of frequent disagreements that affect access to care by patients, and reimbursement for care provided by facilities and practitioners.

To address these disagreements, the American Academy of Physical Medicine and Rehabilitation (AAPM&R) convened an expert panel to develop a consensus position regarding the standards and elements that should be addressed by any decision tool or process intended to determine the correctness of the physician's judgment to admit a patient to a hospital for comprehensive inpatient rehabilitation care.

These standards are the best available consensus opinions of experts on the subject. The AAPM&R hopes that hospitals, physicians, insurers, regulatory agencies and accrediting bodies will review their decision making processes and tools against these standards, and draw upon them for use in resolving disputes regarding individual patient care decisions. It also hopes that the articulation of these standards will help to stimulate the initiation of appropriate research to advance the state of the art and objectivity needed to assure that proper clinical decisions are made while appropriately helping to conserve health care resources.

II. The Decision to Admit a Patient: Reason for Conflict

Facilities, referring physicians and hospitals, patients and payers all have somewhat different concerns regarding the criteria that are utilized to determine whether a patient should be admitted to an IRF. Facilities seek to accurately match the needs of the patient with the capability of the facility so that appropriate payment will follow. Physiatrists seek to effectively utilize their skills and medical knowledge to help patients who are most in need of therapy and require hospital-based care. Referring physicians and hospitals want to transfer patients to the next setting for their continuing care with minimal confusion, delay, or effort. And patients seek to gain access to the best possible care and treatment for their health, well being, and functional improvement. Payers are concerned that only patients who uniquely need care in the rehabilitation hospital are admitted, and seek to identify less expensive alternative settings, such as skilled nursing facilities (SNF), home health care agencies or outpatient services.

Although the cost of care is certainly a consideration in evaluating alternative treatment options, price comparisons only become appropriate once it has been determined that the options being considered are similar (i.e., similar clinical capacities, similar resources, and capability of achieving similar outcomes in

reasonably comparable time frames). Clinicians believe that cost should be a secondary consideration, with clinical need and efficacy being considered as primary factors.

III. Medical Necessity vs. Medical Appropriateness

The term “medical appropriateness” as used here refers to the clinical judgment of a physician that a patient needs care, has the potential to benefit, and that the environment of the rehabilitation hospital or unit is the most appropriate environment for that care to be delivered.

“Medical necessity” or “medically necessary” are terms commonly used by insurers and payers to indicate health care services that meet their criteria for payment under the terms of their contracts. These terms include language that outlines the responsibilities of their plans. Although the language describing these terms, medical appropriateness and medical necessity, is often similar, medical necessity as used by payers is commonly determined by reviewing staff or medical directors not involved in care of the patient. This document focuses on the issues relevant to medical appropriateness. It is recognized that contractual or regulatory requirements may influence reimbursement practices, but those factors are not influential in determining what is clinically proper for an individual patient.

IV. Standards for Determining Medical Appropriateness of Rehabilitation Hospital Admissions

Decisions to admit patients to or discharge them from rehabilitation hospitals are complex and require the consideration of many factors. This complexity precludes the development of rigid quantified criteria applicable to all cases. Because much of this complexity is the result of clinical variations unique to individual patients, the final decisions must be the responsibility of physicians. The standards that follow are intended to be general guidelines based on expert opinion and core principles that guide these decision-making processes.

The expert panel has determined that the following are key concepts and factors that should be addressed by any physician when making an admission decision. Further, any existing tool or admission criteria should be responsive to, and consistent with these standards of good medical practice.

A. Patient Characteristics

Determination to admit patients is based first upon patient characteristics that are related to their needs for both medical management and rehabilitation programs. These characteristics apply to patients with physical and/or cognitive impairments from all diagnostic conditions.

1. The patient is judged to have significant functional deficits and medical and nursing needs regardless of diagnosis that require:
 - a. close medical supervision by a physiatrist or other physician qualified by training and experience;
 - b. 24 hour availability of nurses skilled in rehabilitation; and
 - c. treatment by multiple other licensed rehabilitation professionals (such as physical therapists, occupational therapists, speech language pathologists, and psychologists) as needed in a time intensive and medically coordinated program.
2. The medical stability of the patient and management of medical or surgical co-morbidities are considered to be:
 - a. manageable in the rehabilitation hospital; and
 - b. sufficiently under control so as to permit simultaneous participation in the rehabilitation program.
3. The patient presents as capable of fully participating in the inpatient rehabilitation program (in unusual situations, when it is unclear as to whether the patient is able to fully participate in the

program, a brief period of inpatient care may be required to make the final determination – these circumstances may be referred to as an evaluative admission or a trial admission).

4. The patient has clear functional goals identified to warrant the admission that:
 - a. are realistic;
 - b. offer practical improvements; and
 - c. are expected to be achieved within reasonable time periods.
5. The patient has a high probability of benefiting from the program of care.
6. The patient in most circumstances has a home and available family or care providers such that there is a likelihood of returning the patient to home or a community-based environment.

B. Organizational Characteristics

1. Admission decisions are based upon the capability of the facility to provide the required care (e.g., a patient with a high spinal cord injury should not be accepted for admission to a facility that does not regularly care for this type of patient).
2. The final authority for the decision to admit a patient to a rehabilitation hospital is made by a psychiatrist, or other physician who by training and experience is qualified to make the judgment and has privileges in the organized medical staff of the facility to do so.
3. A nurse or other individual who screens and/or reviews patients referred for admission operates under the direct clinical supervision of the appropriate physician who holds that admitting authority.
4. Medical information sufficient to determine clinical appropriateness for admission to inpatient rehabilitation is reviewed by the admitting physician.
5. General admission criteria for the rehabilitation hospital or unit are written and developed by physicians in conjunction with other members of the rehabilitation team.
6. There is a clear distinction between the medical decision making process and the administrative factors that must also be satisfied in order to admit a patient.
7. All patients who are admitted have been approved by the responsible physician with admitting authority.
8. No patient who is judged medically inappropriate for admission is admitted.

V. Appendices

A. Characteristics of Rehabilitation Hospitals and Units

Rehabilitation hospitals and units have many characteristics that differentiate them from other levels of care, such as acute hospitals, skilled nursing facilities (SNFs) and home care programs. These facilities are licensed as hospitals or rehabilitation hospitals, depending on state law, and are subject to state health department rules and regulations. They provide medical, nursing, rehabilitation therapies and many other services on an intensive basis. Not only do they provide the physical resources of hospitals but in addition have therapeutic gyms, dining facilities and other facilities that are generally not found in other inpatient settings.

Rehabilitation hospitals and units must, under Medicare rules, provide 24-hour, 7-day-a-week availability of physicians and nurses with specialized training or experience in medical rehabilitation. These include psychiatrists, or other physicians with extensive experience in inpatient rehabilitation care, and nurses with training and certification in rehabilitation nursing (CRRN). Therapists include registered or licensed practitioners in physical therapy, occupational therapy, speech/language pathology, therapeutic recreation, and respiratory therapy. Psychologists, social workers, vocational counselors, prosthetists and orthotists, and dieticians or nutritional counselors must also be available. The number of staff members has to be sufficient to provide each patient with at least three hours of therapy daily and meet the rehabilitation medicine and rehabilitation nursing needs of the patients. Medical, surgical, and mental health specialists must be readily available to provide consultations and to obtain access to hospital services necessary for the diagnosis and treatment of the co-morbidities that frequently complicate the course of a patient's stay. Rehabilitation physicians, nurses, therapists and other professional staff members generally communicate as a group at least weekly to discuss the patient's progress and establish goals and time frames, conduct discharge planning, and function daily as an onsite interdisciplinary team of rehabilitation specialists

B. Characteristics of Rehabilitation Hospital Patients

Patients admitted to rehabilitation hospitals and units usually have had a recent onset or significant exacerbation of a serious illness or injury due to one or more medical conditions. Impairments result in reduced abilities to perform activities of daily living and ambulation. These patients are often unsafe when left alone without the help of others to assist them with these activities. They may require medical and post-operative care at a hospital level, such as dialysis, wound care, chemotherapy, hyperalimentation or radiation treatments. Even though patients may be dependent in mobility and self-care and have medical conditions requiring on-going treatment, these patients are relatively medically stable at the time of admission. They normally have the stamina to participate in active rehabilitation therapies for at least three hours per day for five days per week, with the potential to make substantial functional improvement in a reasonable period of time, resulting in the ability to return home or to an equivalent community setting. Often family members or other identified caregivers require intensive training to allow for a safe discharge to the community.

Functional goals for patients usually include improved abilities to move from place to place, greater self-sufficiency in activities of daily living, increased understanding of the disease processes and impairments causing their disabilities, promotion of good physical and mental health practices and training in the use of the equipment needed to increase mobility and self-sufficiency. Other goals during rehabilitation hospital admissions include prescribing and procuring equipment and medical supplies, training of family members and other caregivers, and transition planning to safe discharge environments.

C. Characteristics of Skilled Nursing Facilities

There are settings other than hospitals where medical rehabilitation services are delivered. The question frequently arises as to whether a nursing home or skilled nursing facility can substitute for IRF care in specific cases. In assessing whether SNF or other non-IRF care would be medically appropriate and provide equivalent rehabilitation services, one must consider the differences between SNFs and IRFs. One must also consider the fact that there are significant variations among SNFs.

Although SNFs vary considerably in their ability to furnish rehabilitation services, there are minimum standards SNFs are required to meet to participate in the Medicare program. Although SNFs may provide more than the minimum level of care required for Medicare participation, they are not required to do so.

SNF Minimal Medicare Facility Elements

1. Admission to SNF must be approved by a physician.
2. A comprehensive care plan must be developed by physician and nurse with input from other staff only “to the extent practicable.”
3. A physician must provide general medical supervision of the patient but this does not necessarily include management of therapy services.
4. Physician visits are required once every 30 days (and once every 60 days after first 3 months) and mid-level practitioners can substitute for physicians on intermittent basis.
5. Patient assessments are required quarterly or within 14 days of a significant change.
6. There is no requirement for interdisciplinary team conferences.
7. Therapy providers can determine, independently of one another, when therapy will end.
8. Twenty-four hour RN staffing is not required.
9. Rehabilitation nursing is not required.
10. Physical, occupational and speech therapy services must be available, if required by the patient’s plan of care, either through facility staff or outside contractors.
11. There is no requirement that the patient be provided with 3 hours or any minimum amount of therapeutic services per day.
12. Laboratory, radiological and emergency visits are not required to be available on-site.
13. There is no requirement for a director of rehabilitation position.
14. There is no requirement that the SNF provide prosthetic or orthotic services.
15. Social services provided by a social worker must be available.

D. Suggested Decision Pathways

The next two pages include pathways designed to facilitate the decisions related to admitting patients to hospital level rehabilitation facilities, and continuing their care once admitted. The information utilized in their development is included in the text of this report. This text should be consulted when those using the decision pathways desire additional information regarding the various considerations included in the Decision Pathways.

Patient with impaired function who no longer requires acute medical inpatient setting

Q#1: Could inpatient rehab make this individual function significantly better?

Yes?

No?

Do Not Admit

Q #2: Could any lower level of care accomplish the same goals nearly as effectively?

Yes?

No?

Admit to Hospital Level Rehab

Q #3: Evaluate "nearly" (from Q #2), and weigh cost/benefit of alternate settings.

Little difference

Significant advantage to hospital level rehab in medical safety, timeframe or ultimate level of goal achievement

Choose lower level of care

Admit to Hospital Level Rehab

Considerations in answering Q #1

- *Is the functional loss significant?*
- *Does patient have ability/willingness to participate in therapy?*
- *Would amount of achievable improvement likely alter post-discharge independence/dependence?*
- *Do support services exist to facilitate eventual community discharge or would functional improvement materially benefit in SNF or other facility?*
- *Are acute medical problems sufficiently controlled to allow focus on rehab?*

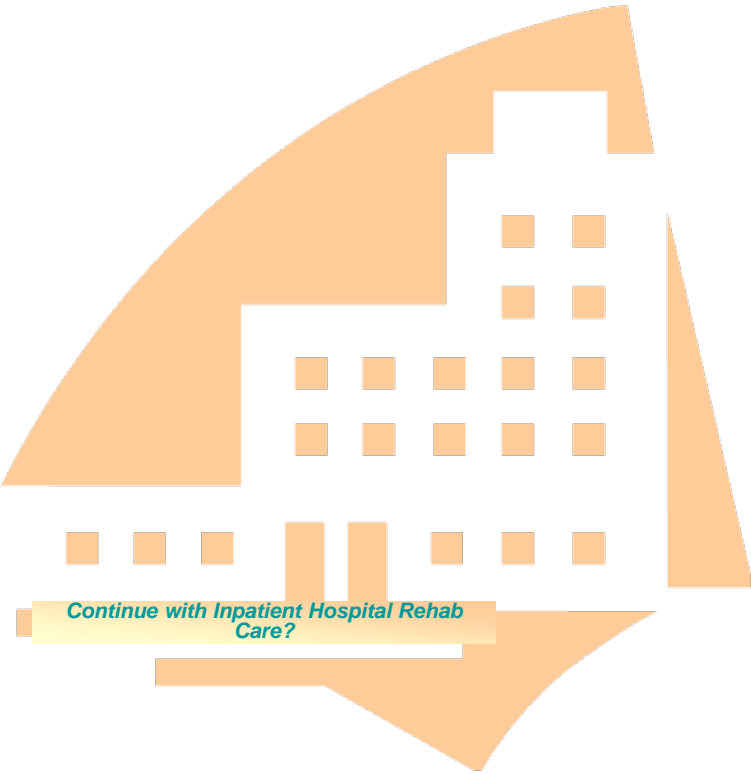
Considerations in answering Q #2 (see * below)

Does patient require rehab nursing and/or more frequent/more accessible medical oversight than non-hospital level rehab can provide?

- *Does patient require multiple therapies cooperating within a common treatment plan, frequently reviewed and revised based on multidisciplinary input?*
- *Is there need for cross-disciplinary reinforcement of therapies?*
- *Does rate of change require frequent re-evaluation/adjustment of multidisciplinary plan?*
- *Would time course for achievement of goals be affected by setting?*
- *Is there a requirement for specialized equipment/assistive devices?*
- *Will >3^o of therapy daily achieve goals more effectively than <3^o?*
- *Do behavioral health/psychological needs require regular assessment and treatment?*
- ** One or more yes answers could support admission to hospital level rehabilitation.*



Post-Admit:



Q #4: Is satisfactory progress being made toward achieving inpatient hospital level rehab goals?

Yes?



Continue with Inpatient Hospital Rehab Care

No?



Q #5: Would **modification in care plan** be likely to promptly achieve/restore progress and at an appropriate rate for hospital level rehab?

Yes?



Continue with Inpatient Hospital Rehab Care

No?



Discharge to alternative care facility
[Note: if patient is discharged, readmission to hospital level rehab could be considered when clinical circumstances change.]

E. Members of Expert Panel

1. Task Force Members

John L. Melvin, MD, MMSc, Chair

John M. Melvin, MD is the Michie Professor and Chair of the Department of Rehabilitation Medicine at Jefferson Medical College. He is also the Chair of the Department of Rehabilitation Medicine at Thomas Jefferson University Hospital. From 1991-2002, he was Vice-President of Medical Affairs at MossRehab of Philadelphia, PA. Previously, he had been Medical Director of the Curative Rehabilitation Center of Milwaukee. Dr. Melvin has had clinical administrative responsibility for hospital-based inpatient rehabilitation programs since 1973. He was Co-Principal Investigator with Robert Kane, MD of a grant sponsored by the Health Care Financing Administration (HCFA) that resulted in the 1986 RAND publication: *Charges and Outcomes for Rehabilitation Care, Implications for Prospective Payment System*. Dr. Melvin was a member of the committee of the American Academy of PM&R (AAPM&R) and the American Congress of Rehabilitation Medicine upon whose 1978 report HCFA (now CMS) partially based its criteria for the classification of hospitals as inpatient rehabilitation facilities in 1984. He is a former president of the AAPM&R and National Association of Rehabilitation Facilities (currently the American Medical Rehabilitation Providers Association).

Bruce M. Gans, MD, Board of Governors Liaison

Bruce M. Gans, MD is Executive Vice President and Chief Medical Officer for the Kessler Institute for Rehabilitation, where he is responsible for physician practices, academic affairs, and clinical quality for all in- and out-patient programs and services. He is also Professor of Physical Medicine and Rehabilitation at the UMDNJ-New Jersey Medical School. Previously, Dr. Gans served as Chairman of the Departments of PM&R at Long Island Jewish Medical Center, and North Shore University Hospital. While in New York, he held an appointment as Professor of Rehabilitation Medicine at the Albert Einstein College of Medicine of Yeshiva University. From 1989 to 1999, he was President of the Rehabilitation Institute of Michigan. At Wayne State University School of Medicine, he was Professor and Chairman of the Department of Physical Medicine and Rehabilitation and served as Psychiatrist-in-Chief for the Detroit Medical Center. He was previously Chairman of the Department of Rehabilitation Medicine at the New England Medical Center and Professor and Chairman of Rehabilitation Medicine at Tufts University School of Medicine. He is currently serving as the immediate Past President of the AAPM&R and on the governing board of the American Medical Rehabilitation Providers Association.

Leighton Chan, MD, MPH

Leighton Chan, MD, MPH is an Associate Professor in the Department of Rehabilitation Medicine at the University of Washington in Seattle. He completed his BA in Political Science at Dartmouth College in 1983. After receiving a medical doctorate from the UCLA School of Medicine, Dr. Chan was a resident in PM&R at the University of Washington. He went on to obtain a MS in Rehabilitation Medicine and a MPH in Health Services during his Robert Wood Johnson Clinical Scholars Fellowship. At the University of Washington Medical Center, he is co-director of the Pulmonary Rehabilitation Program, and an Attending Physician at the Electromyography Laboratory. Dr. Chan is an expert in health policy, and has published extensively on the topic of health care delivery to the Medicare population. His articles have appeared in *The New England Journal of Medicine (JAMA)*, and the *Archives of PM&R*. He has held positions in both the U.S. Senate and House of Representatives and has been involved in successful grant applications to NIH, CDC, CMS, and NIDRR. He is currently on the Board of the American Academy of PM&R.

Dexanne B. Clohan, MD

Dexanne B. Clohan, MD, Sr. Vice President and Chief Medical Officer at HealthSouth Corp., has been active in aspects of health care ranging from policy development to clinical practice for over 20 years. In her current position, she is responsible for development and implementation of clinical and quality initiatives. In addition, she coordinates the company's clinical research efforts and the

evaluation of new technology. Dr. Clohan received her Doctor of Medicine and Masters degree in Administration from George Washington University in Washington, D.C. She is a fellow of the American Board of Physical Medicine and Rehabilitation and received her postgraduate medical education at the University of California, Irvine. Her clinical practice has focused on inpatient rehabilitation, and she has been active in leadership roles in physician organizations including the AMA, the California Medical Association, and the American Academy of Physical Medicine and Rehabilitation. Her committee work with these organizations has primarily focused on ethics, performance measures, and legislation.

Martin Grabois, MD

Martin Grabois, MD is currently Professor and Chairman of the Department of Physical Medicine and Rehabilitation (PM&R) and Professor of Anesthesiology at Baylor College of Medicine, Houston, Texas. He has received numerous awards including the American Congress of Rehabilitation Medicine's Gold Key Award and the American Academy of PM&R's Frank H. Krusen Award. He is actively involved in various national and international PM&R organizations and has served as president of the American Academy of PM&R, the Association of Academic Physiatrists, the American Congress of Rehabilitation Medicine, the International Rehabilitation Medicine Association and the American Pain Society. He is also past president of the Foundation for PM&R and serves on the Board of American Academy of Pain Medicine and as Chairman of the RI Health and Function Commission. He serves as editor of the *Critical Reviews in Physical Medicine and Rehabilitation*. He has conducted over 200 invited presentations worldwide and is widely published, including as editor or co editor of books, book chapters, publications in peer review journals, abstracts and proceedings on largely PM&R related topics.

Kurt Hoppe, MD

Kurt Hoppe, MD is a Diplomate of the American Board of PM&R and American Board of Electrodiagnostic Medicine. He is the Chair of the American Academy of PM&R's Health Policy and Legislation Committee. Dr. Hoppe practices at the Mayo Clinic in Rochester, Minnesota with a focus on musculoskeletal rehabilitation, spinal cord injury medicine and disability. Dr. Hoppe attended University of Minnesota Medical School in Minneapolis, Minnesota and completed his PM&R residency at Mayo Graduate School of Medicine, Mayo Clinic, Rochester, Minnesota.

Kristjan T. Ragnarsson, MD

Kristjan T. Ragnarsson, MD is a graduate of the University of Iceland School of Medicine and completed a residency in PM&R at New York University Medical Center, followed by a Clinical Research Fellowship in Spinal Cord Injury (SCI) Medicine and a faculty appointment at that institution. In 1986, he was appointed Professor and Chairman of the Department of Rehabilitation Medicine at Mount Sinai, a position that he has held since and where he is responsible for the growth of the department's clinical and academic programs. He served as President of Mt Sinai Hospital's Medical Board (1995-1997) and the Chairman of the Mount Sinai School of Medicine Faculty Practice Associates Board of Governors (1997-2003). As an expert on SCI, he has served as Director of the Mount Sinai Spinal Cord Injury Model System since 1990, as Past President of the American Spinal Injury Association, as a former Board Member of the American Paraplegia Society, and as a member of the Editorial Board of the Journal of Spinal Cord and the Daniel Heumann Fund for Spinal Cord Research, for the NIH National Institute on Disability and Rehabilitation Research. He has lectured extensively and published over 120 scientific articles and book chapters.

Leon Reinstein, MD

Leon Reinstein, MD, is the Medical Director of Sinai Hospital of Baltimore's Comprehensive Inpatient Rehabilitation Unit and the Associate Physiatrist-In-Chief. He is also Clinical Professor of PM&R at the Virginia Commonwealth University, Medical College of Virginia. From 1973 to 1975, he served on the faculty of the Department of Rehabilitation Medicine at Thomas Jefferson University Hospital in Philadelphia, PA. In 1975, he was on the faculty of the University of Maryland School of Medicine serving as Associate Professor and Acting Chairman from 1983 to 1985 and as Clinical

Professor of both Neurology and Epidemiology and Preventive Medicine. In addition, he has served as Associate Professor of PM&R at the Johns Hopkins University School of Medicine, as a Visiting Professor to the Departments of PM&R at Harvard Medical School in Boston, and at Baylor Colleges of Medicine in both Dallas and Houston. As a leader in the field, Dr. Reinstein was President of the American Academy of PM&R and is the organization's representative to the Council of Medical Specialty Societies (CMSS) and a delegate to the AMA. He has authored forty-three abstracts, thirty-three publications, and two book chapters.

Elliot J. Roth, MD

Elliot J. Roth, MD is the Donnelley Senior Vice President for Medical Affairs and Medical Director of the Rehabilitation Institute of Chicago (RIC), the Paul B. Magnuson Professor and Chairman of the Department of PM&R at Northwestern (NW) University Feinberg School of Medicine, and the Chairman of the Department of Rehabilitation Medicine at NW Memorial Hospital. He also is the Project Director of the Rehabilitation Research and Training Center on Technology Promoting Integration for Stroke Survivors: Overcoming Societal Barriers, sponsored by the US NIDRR and served on the Expert Panel to develop Stroke Rehabilitation Clinical Practice Guidelines for the U.S. Agency for HCPR in 1995, and as a member of the Panel for the NIH Consensus Development Conference on Brain Injury Rehabilitation in 1998. He was a member of Technical Expert Panels to assess prospective payment systems for rehabilitation in 1997 and 1998, and to develop inpatient rehabilitation quality measures in 2002 and 2003. Dr. Roth is the recipient of numerous awards and has published more than ninety peer-reviewed papers, book chapters, and other articles in medical rehabilitation.

M. Elizabeth Sandel, MD

Elizabeth Sandel, MD, is the Medical Director of the Kaiser Foundation Rehabilitation Center, Chief of PM&R, and Clinical Professor of PM&R at the University of California at Davis. Her clinical practice focuses on neurologic and neuromuscular disorders and interdisciplinary rehabilitation care in inpatient and outpatient settings. She held positions in medical centers including as medical staff of Magee Rehabilitation Hospital, Thomas Jefferson University Hospital, Mediplex Rehabilitation Center, Cooper Hospital/University Medical Center, and the Hospital of the University of Pennsylvania and has held several academic appointments. She has published and lectured in the fields of neurorehabilitation, and rehabilitation medicine and received awards from the New Jersey Rehabilitation Association and the Pennsylvania Head Injury Foundation for her work in brain injury rehabilitation. She was an invited panelist at the IOM and the National Institutes of Health for discussions concerning inpatient rehabilitation. Dr. Sandel is currently serving on the AAPM&R Board of Governors.

2. Technical Advisors

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Allen W. Heinemann, PhD completed his doctoral degree in clinical psychology at the University of Kansas with a specialty focus in rehabilitation. Since 1985, he has worked at the Rehabilitation Institute of Chicago where he directs the Center for Rehabilitation Outcomes Research, and is associate director of Research at RIC and professor in the Department of PM&R at the Feinberg School of Medicine, Northwestern University. He is the author of more than 120 articles in peer-reviewed publications and is the recipient of funding by the NIDRR (RRTC on Measuring Rehabilitation Outcomes and Effectiveness). He serves as a study section member for the NIH; as the ACRM Editor for the Archives of PM&R on the editorial boards of NeuroRehabilitation, International Journal of Rehabilitation and Health, Journal of Outcome Measurement, and the Journal of Head Trauma Rehabilitation. His research interests focus on health services research, psychosocial aspects of rehabilitation, and measurement issues in rehabilitation.

Carolyn C. Zollar, JD

Carolyn C. Zollar, JD is the Vice President for Governmental Relations and Policy Development for the American Medical Rehabilitation Providers Association since 1998. She was formerly the Vice President for Policy and General Counsel for the American Rehabilitation Association, formerly the National Association of Rehabilitation Facilities (NARF) (1982-1998). She is also a co-chair of the National Rehabilitation Caucus, a coalition of over 50 rehabilitation professional, consumer and provider organizations. She is a member of various technical advisory panels on rehabilitation issues and post acute care for the Centers for Medicare and Medicaid Services, including those in the IRF-PPS and Rehabilitation Indicators.

She has an extensive background in the prospective payment system for inpatient rehabilitation facilities and prior payments systems.

She has worked for the US Senate and the US House of Representatives as a consultant for the White House and was in private law practice for 7 years.

She holds a BA from Smith College, MA from Columbia University and a JD from the Washington College of Law, American University, Washington, DC. She is featured in Who's Who in American Law and Who's Who in America. She speaks and writes extensively about health care, Medicare, rehabilitation, disability, budget issues, and legislative advocacy.

Grace M. Carter, PhD

Grace M. Carter, PhD, joined the RAND Corporation in 1968 serving as a member of the senior staff and as resident consultant and led a project that assisted the Centers for Medicare and Medicaid Services (CMS) in the development and implementation of the prospective payment system (PPS), now utilized by the agency for reimbursement of inpatient rehabilitation services for Medicare patients. From 1991 to 1998, she led the RAND/UCLA/Harvard Center for Health Care Financing Policy Research where she was responsible for several projects that evaluated many aspects of the PPS including: the effect of changes in hospital coding behavior on total PPS payment, the calculation of DRG weights, payment for transfer cases, and alternative outlier payment policies. She is also a member of the Technical Advisory Panel for the Urban Institute's project on Medicare's Skilled Nursing Facilities' Payment and for RTI's Technical Expert Panel on quality indicators for inpatient rehabilitation.

Sam Fleming

Sam Fleming is the President of Fleming-AOD, Inc, a Washington DC based firm specializing in Medicare policy analysis utilizing computer models. Mr. Fleming has worked with the rehabilitation industry since 1990 providing services to both individual rehabilitation facilities and the various incarnations of the national trade association. His current responsibilities include policy analysis, advocacy and education, as well as the design, construction, maintenance and development of the American Medical Rehabilitation Providers Association's outcomes system, eRehabData.

3. Consultant

Malcolm H. Morrison, PhD

Malcolm H. Morrison, PhD, president and CEO of Morrison Informatics, Inc., served in the initial phase as a consultant to the Medical Inpatient Rehabilitation Criteria Task Force on the document, “Standards for Assessing Medical Appropriateness Criteria for Admitting Patients to Rehabilitation Hospitals or Units”. Dr. Morrison is nationally recognized in the field of management information analysis in healthcare. With extensive education and experience in aging, long term care, disability and rehabilitation/post-acute healthcare, with expertise in management information analysis, he provides consultation to several government agencies including MedPAC, CMS, and The Department of Veterans Affairs. He was a member of the Legislative and Rehabilitation Facility Committees of the Federation of American Health Systems, and on the Board of Trustees of CARF - The Rehabilitation Accreditation Commission. Dr. Morrison holds a Ph.D. in Social Welfare from Brandeis University and a Master's in Public Administration with a Certificate in Aging from the University of Michigan.

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Disclaimer

These *Standards for Assessing Medical Appropriateness Criteria for Admitting Patients to Rehabilitation Hospitals or Units* (“Standards”) provide information to consider when deciding whether to admit a patient to a rehabilitation hospital or unit. The Standards are not intended to be all-inclusive or otherwise limit the inquiry and consideration applicable to decisions regarding a patient’s rehabilitation needs. The Standards neither endorse nor make any representation regarding the qualifications, capabilities, skill or competence of any individual physician. The Standards present general information for educational purposes only and are not intended nor should it be used as a substitute for professional medical advice. The American Academy of Physical Medicine and Rehabilitation (AAPM&R) and the individuals who participated in creating the Standards expressly disclaim all responsibility and liability arising from your use of or reliance on the Standards, and assume no responsibility and liability arising from your use of or reliance on the Standards, and assume no responsibility or liability for any claims that may result directly or indirectly from your use of the information.