# The Current Reality of the 75% Rule

**December 7, 2005**

The attached issue brief describes the current 75% Rule environment and summarizes the most recent discharge data from inpatient rehabilitation facilities (IRF), as analyzed by The Moran Company. It provides a more complete understanding of the reality of the 75% Rule's harm to patients than the incomplete data provided in the Centers for Medicare & Medicaid Services' (CMS) November 2005 correspondence to Wall Street investors and analysts. In addition, **the issue brief affirms the need to support the Senate-passed language that would extend the 50 percent threshold for an additional two years and establish a National Advisory Council on Medical Rehabilitation to develop recommendations on how to modernize the 75% Rule.**

The following are the key points from the attached 75% Rule issue brief.

- November 2005 CMS correspondence to Wall Street focuses on outdated information that fails to capture the 75% Rule's impact since it was reintroduced.

- During the first year (July 2004 through June 2005) under a 50 percent threshold, approximately 40,000 fewer patients were able to access inpatient rehabilitation. In the first quarter of Year 2, 16,000 fewer patients were treated in IRFs, according to data from 75 percent of the IRF field. If this pattern holds for the remaining three quarters (a conservatively low estimate) and is applied to 100 percent of the IRF field, it is likely that 64,000 fewer patients will be treated in IRFs during Year 2 of the 75% Rule. CMS acknowledges that the number of patients affected is greater than it projected.

- CMS suggests that it is clinically suitable and fiscally appropriate for these patients to be treated in a less-intensive setting. But doing so produces negligible Medicare savings in the short-run, and possibly leads to greater Medicare costs in the long-run for patients who experience preventable complications.

- Many IRF patients have medically-complex conditions, such as post-surgery cancer, transplant, and cardiac diagnoses, that require the intensive services provided by specialty-trained physicians and nurses in IRFs. This level of care is rarely found in any other health setting.

- Only four percent of Medicare patients discharged from a hospital are referred for inpatient rehabilitation. And CMS data show that only 3 of 10 joint replacement patients are treated in an IRF.

- The current volatility in the IRF field, caused by the phasing-in of the 75% Rule and recent changes to the Medicare payment system for IRFs, is directly translating into decreasing access for patients.

- To preserve access to care, policymakers should mitigate this growing instability by supporting the Senate-passed language on the 75% Rule. This would extend the 50 percent threshold for two years, which will provide HHS and the field the opportunity to develop recommendations on how to modernize the 75% Rule and conduct more research needed to develop a sound remedy.

# The Current Reality of the 75% Rule

The 75% Rule pertaining to inpatient rehabilitation facilities (IRF) continues to restrict access to care for thousands of Medicare beneficiaries and other patients. Policymakers addressing the 75% Rule must rely on current data, such as those discussed below, which capture this complex and dynamic environment. New 2005 data show the 75% Rule's worsening negative impact on patients. **These data provide a more complete understanding of the current reality of the 75% Rule's harm to patients than indicated by the incomplete data provided in the Centers for Medicare & Medicaid Services' (CMS) November 2005 correspondence to Wall Street investors and analysts.**

The phase-in of the 75% Rule was initiated July 2004 with a 50 percent compliance threshold. In the second program year, which began July 1, 2005, the threshold escalated to 60 percent. Under CMS' schedule, a 65 percent threshold will take effect July 1, 2006 and be followed by a permanent 75% percent threshold beginning July 1, 2007.

Recently, the Senate took decisive action to mitigate the harm of the 75% Rule by including in its budget reconciliation package provisions from S. 1405, championed by Senators Ben Nelson (D-NE), Rick Santorum (R-PA), and Jim Bunning (R-KY) to stop the erosion of inpatient rehabilitation care for Medicare beneficiaries. **This Senate-passed language would apply the 50 percent threshold for an additional two years and establish a National Advisory Council on Medical Rehabilitation to develop recommendations on how to modernize the 75% Rule so that it is clinically sound.**

## IRF Access Could Be Eliminated for 64,000 During Year 2 of 75% Rule Phase-In

***Year 2 (60% Threshold).*** In the first quarter of Year 2, 16,000 fewer patients were treated in IRFs, according to a new Moran Company analysis (attached) of the latest IRF discharge data from three quarters of the IRF field. If this pattern holds for the remaining three quarters (a conservatively low estimate) and is applied to 100 percent of the IRF field, **it is likely that 64,000 fewer patients will be treated in IRFs during Year 2 of the 75% Rule.** Figure 1 compares IRF discharges from the third quarter of the past four years to illustrate the drastic scale of this drop from 2004 to 2005. **Figure 2 shows that the anticipated annual drop in discharges for Year 2 – at least 64,000 patients – is 12 times greater than CMS' projection for Year 2.**

**Figure 1: Trend in IRF Discharges**
Third Quarter 2002 - 2005

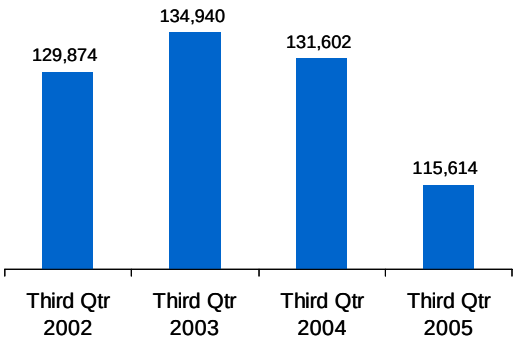
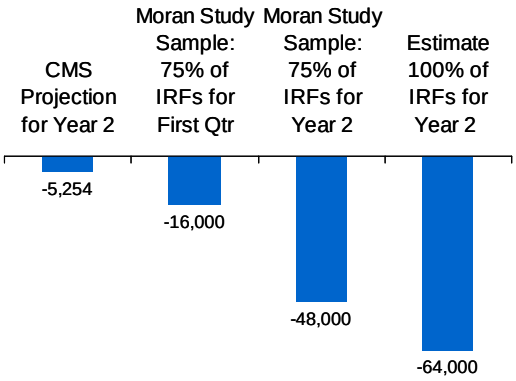



**Figure 2: Estimate of Reduction in IRF Discharges in Year 2 with 60% Threshold**

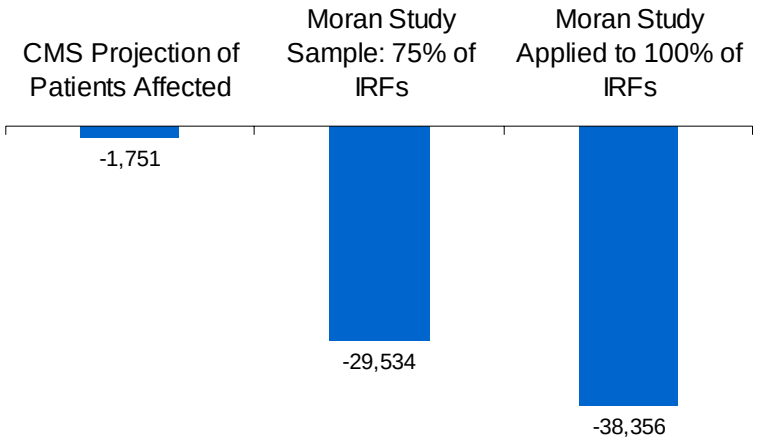



Source: Moran Company, Dec 2005, discharges from 75% of IRFs

## Nearly 40,000 Lost Access to IRF Care During Year 1 of 75% Rule Phase-in

***Year 1 (50% Threshold).*** The estimated 64,000 reduction in IRF discharges in Year 2 of the phase-in follows a reduction of nearly 40,000 IRF discharges during Year 1 of the phase-in, shown in Figure 3. **The number of Medicare beneficiaries who lost access to IRF care in the first year was 22 times greater than the impact projected by CMS**. CMS acknowledges that the number of patients affected is greater than projected by the agency.

**Figure 3: Reduction in IRF Discharges in Year 1 with 50% Threshold**

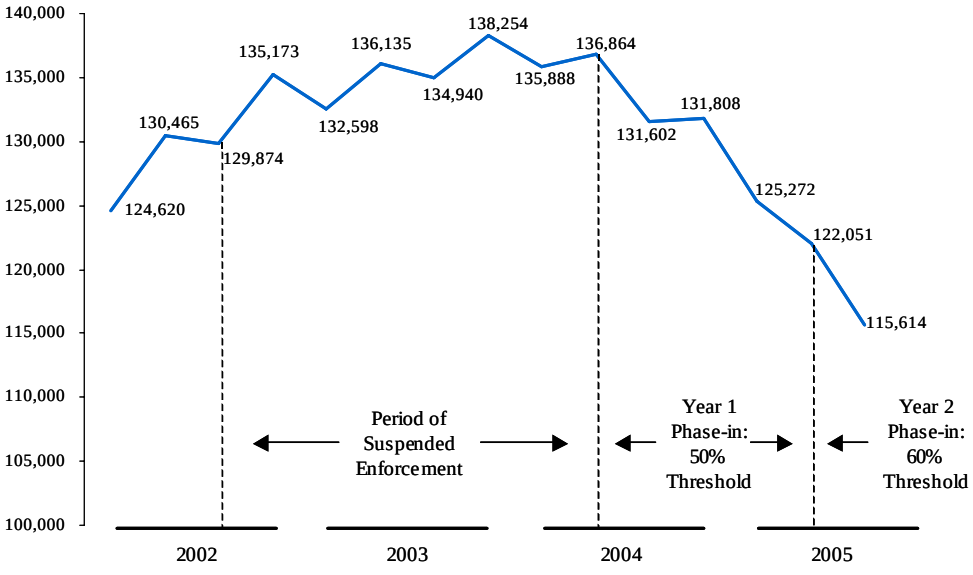



Source: Moran Company, Sept. 2005, discharges from 75% of IRFs

## Many Thousands of Medically Complex Patients Are Losing Access to IRF Care

The patients who are losing access to inpatient rehabilitation services in IRFs due to the 75% Rule include many medically complex patients who are appropriate for the intensive rehabilitation and the medical oversight provided by specialty-trained physicians and nurses in IRFs. It is rare to find clinical capacity equal to IRF levels in any other medical setting. Yet the 75% Rule is forcing very sick patients such as post-surgery cancer, transplant, cardiac, and other patients to turn to settings that may not be suitable for their care. Unfortunately, if the phase-in of the 75% Rule is allowed to continue, the downward trend seen in Figure 3 will continue to reflect greater numbers of patients losing access to inpatient rehabilitation.

**Figure 4: Rehab Discharges for All Payers by Quarter**




Source: Moran Company, Dec 2005, discharges from 75% of IRFs

It is inappropriate to reduce access to care for these medically-complex patients by continuing to phase-in the 75% Rule, especially since doing so produces negligible, if any, cost savings to Medicare in the long-run. For example, the November 30, 2005 CMS correspondence to Wall Street demonstrates that **Medicare pays only slightly more for IRF care versus skilled nursing care for total knee replacement patients, total hip replacement patients, and hip fracture patients.** These comparative data do not account for any additional long-term costs paid by Medicare due to re-hospitalizations caused by preventable complications and potentially longer lengths of stay in a less-intensive setting. **It is inappropriate to place medically complex patients in less-intensive settings that commonly have substantially lower clinical capacity, in order to gain very modest savings for Medicare; especially without the clinical evidence ensuring these patients can achieve appropriate function and quality of life in the less-intensive setting. At this time, no such evidence exists. Research on these matters is currently underway by the National Rehabilitation Hospital policy institute and more is needed.**

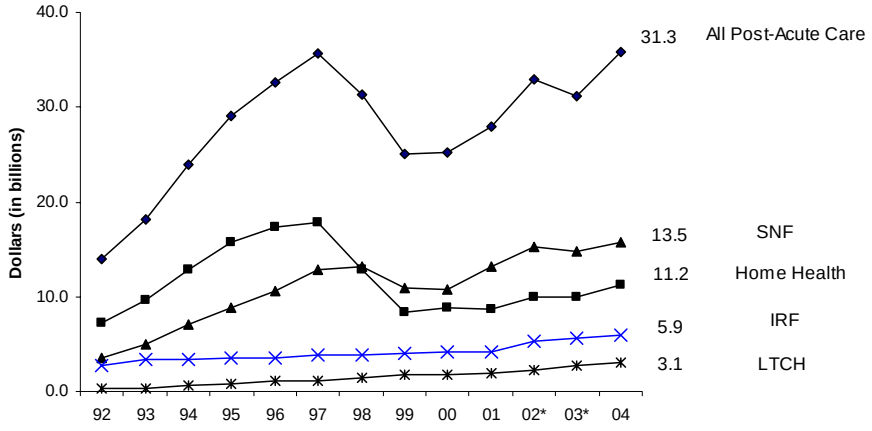
## IRF Growth Is Modest and Consistent with Other Post-Acute Settings

Historically, physicians refer a small minority of their patients to IRFs following surgery since most patients do not need this level of post-acute care**. Only about four percent of all Medicare beneficiaries go to an IRF following hospitalization**. And the November 30, 2005 CMS correspondence to Wall Street demonstrates that 7 out of 10 knee replacement patients are discharged to skilled nursing facilities, home health agencies, and other settings – with the remaining 30 percent going to IRFs. **Clearly, physicians in acute hospitals and IRFs are judicious in their use of IRF care and carefully consider patients' medical need and appropriateness for inpatient rehabilitation.** Unfortunately, the 75% Rule is diminishing the ability of physicians to refer patients to the most appropriate setting after surgery. Such a decision should only be within the purview of physicians and their patients.

**Figure 5 shows that the growth of Medicare payments to IRFs has been modest and stable – approximately 4 percent per year** – and consistent with the growing Medicare population. Medicare payments to IRFs will likely decline during 2004 and 2005 due to the 75% Rule.

**FIGURE 5**

### Medicare Spending for Post-Acute Care, by setting, 1992-2004




Note: Dollars are program spending figures and do not include beneficiary co-payments.
*Estimated
Source: CMS, Office of the Actuary, 2003

**CMS recently made adjustments to the IRF payment system that attempt to re-align payments with actual costs, which will further reduce Medicare spending on IRFs in fiscal year 2006.** These changes, which included an across-the-board cut in payments of 1.9 percent, did not account for the negative impact of the 75% Rule which began in 2004. The volatility caused by both the 75% Rule and this payment reduction have created considerable challenges for IRFs and their ability to provide care. Continued phase-in of the 75% Rule will create further instability in this already rapidly changing environment.

## Conclusion

Given the dramatic reduction in access to inpatient rehabilitation under the 50 percent threshold, the phasing-in of the 75% Rule should not continue to escalate. To do so would place even further stress on the inpatient rehabilitation field, which directly translates into additional barriers to access for Medicare beneficiaries and other patients. As noted, the minimal financial savings for the Medicare program do not justify this restriction of services for Medicare beneficiaries.

Policymakers should mitigate the growing volatility caused by the initial phase-in of the 60 percent threshold by supporting the Senate-passed language on the 75% Rule, which would prevent further restrictions on access to care for thousands of patients by extending the 50 percent level for two years. Also, CMS recently made adjustments to the IRF payment system that will re-align payments and will further reduce Medicare spending on IRFs in fiscal year 2006 – adding more volatility to the field. **Extending the 50 percent threshold level for two additional years maintains a compliance level greater than CMS' projected impact of a fully implemented 75% Rule would achieve, while providing a reasonable timeframe for more research and the development of a modernized 75% Rule that incorporates twenty-first century medical advances.**

# Utilization Trends in Inpatient Rehabilitation: Update Through Q III 2005

December 2005

THE MORAN COMPANY

# Utilization Trends in Inpatient Rehabilitation: Update Through Q III 2005

## EXECUTIVE SUMMARY

The Moran Company was engaged by the Federation of American Hospitals, the American Hospital Association, and the American Medical Rehabilitation Providers Association to update prior analyses we had performed evaluating the impact of changes in provider qualification rules for inpatient rehabilitation facilities (IRFs) under Medicare. In this follow-on study, we have:

- Acquired data on discharges of IRF patients (from Medicare and other payers) through the end of the third quarter of CY 2005.

- Extended our prior analysis by acquiring data from both of the largest data benchmarking services used by IRFs ($UDS_{MR}$ and eRehabData®), which together represent data on more than 75% of all Medicare IRF discharges.

The findings of this analysis confirm the findings of our prior analyses. Specifically, we find that:

- Immediately following implementation of the new enforcement regime in the Final Rule of May, 2004, the prior growth trend in IRF discharges ended, and volume has declined steadily over the ensuing five quarters.

- Medicare IRF discharges were down 7.7% in program year (PY) 2005 with a 50% compliance threshold (July 2004 through June 2005) relative to PY 2004 – a reduction of nearly 30,000 patients.

- The total number of patients affected in program year 2005 is close to 40,000 since the data analyzed only accounts for approximately 77% of the IRF field.

- The run rate for Q III 2005 (the first quarter of the 2006 program year) shows nearly 16,000 fewer discharges than Q III 2004; if this rate continues for the balance of the 2006 program year, it would imply an annual level of discharges in the range of 48,000 fewer cases in 2006 than in 2005.

- We have no evidence to suggest that a new equilibrium has been reached. Only a small number of facilities have begun operating at the 60% compliance threshold of the second program year due to the timeframe of their hospital cost report.

- In the first three quarters of 2005, the downtrend, which affects all payers, is equivalent to a -16.0% annualized decline in discharges.

- On an annualized basis, the decline in Medicare volume over the last four quarters is equivalent to approximately 52,000 cases.

- This decline is not uniform across all diagnostic categories; five diagnostic categories out of 22 explain more than the entire decline in caseload from Q II 03 to Q III 05.[1]

- These diagnostic categories are those which CMS has indicated, in the preambles to the proposed and final rules, to be likely to be subject to the most scrutiny under the new enforcement policy.

[1] Some of the other categories show increases that offset a portion of the volume reduction experienced by these particular categories.

# Utilization Trends in Inpatient Rehabilitation: Update Through Q III 2005

## Data Employed in the Analysis

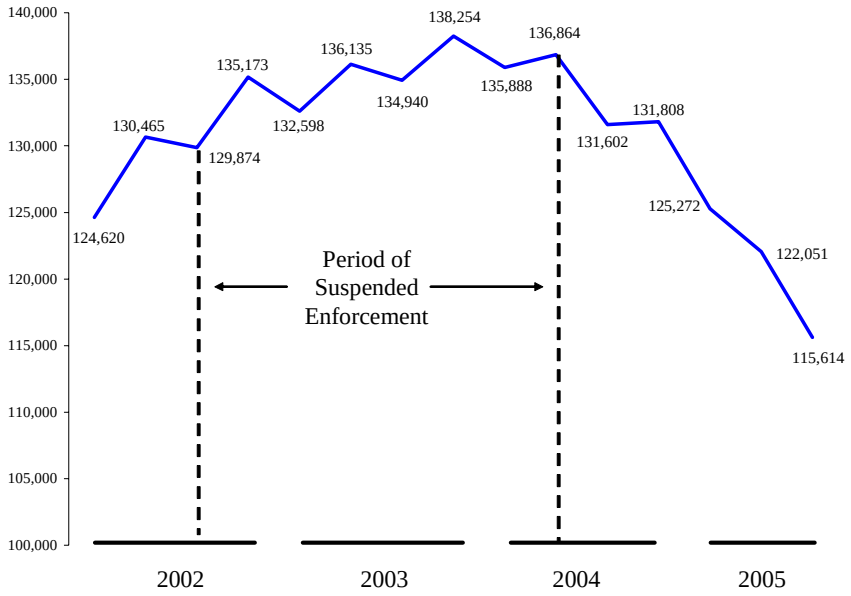
We requested and received fifteen quarters of confidential data for the time span of July 2002 through September 2005. Both data services sent us data on only those providers who had participated continuously in the respective services for each of the fifteen quarters ending with the third quarter of 2005 – i.e., so-called "same store" tabulations. Because rehabilitation hospitals use only one data service at a time, the provider lists underlying these samples represent unduplicated counts of discharges.[2] In the four quarters of program year 2005 (ending Q II 2005) with a 50% compliance threshold, these two sources reported "same store" discharges of 355,682 Medicare beneficiaries, and 510,773 cases from all payers. Collectively, this cohort represents approximately 77% of the 459,682 total Medicare IRF discharges predicted for 2005 in the Impact Analysis accompanying the 2004 Final Rule.

### Overall Volume Trends

Figure One summarizes the volume trend data, for all discharges, over the most recent four quarter period for which data are available.

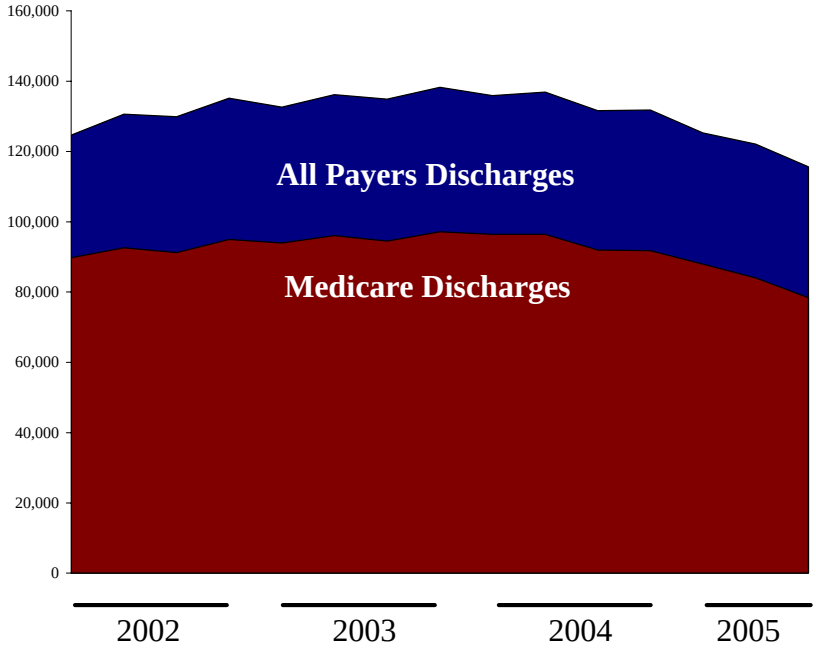
[2] Providers who changed data services during this period are, therefore, excluded from this analysis. Because of their exclusion, the number of discharges observed in the prior periods (Q II 2002 – Q2005) declined slightly relative to our last analysis.

**Figure One: All Payers Rehab Discharges by Quarter**



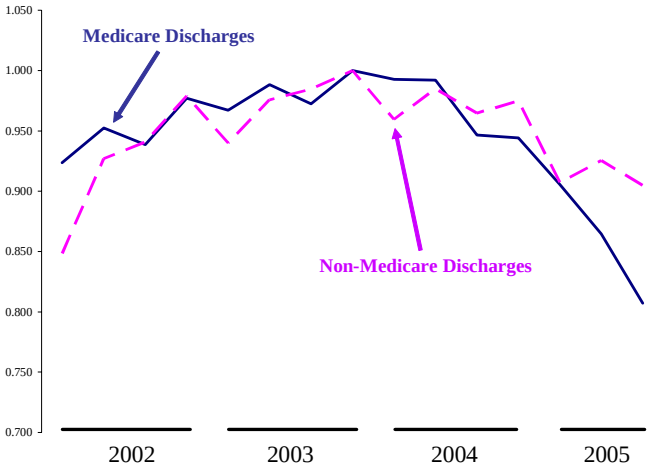

As demonstrated in Figure Two, this caseload trend is consistent across payer types.

**Figure Two: Inpatient Rehab Discharges by Quarter**




As shown in Figure Two, Medicare discharge volumes have been moving in tandem with the total discharge volume trend. This is hardly surprising, since the Medicare discharge volumes comprise 69.6% of the total caseload volume the last four quarters for which we have data.

**Figure Three: Medicare v. Non-Medicare Discharges**
**(Q4 2003 = 100 Basis)**




In Figure Three, we present our analysis of trends in non-Medicare caseload volume, observed separately from the Medicare cases.

In that Figure, we have separately tabulated Medicare and non-Medicare discharges, and then scaled the respective discharge time series to their respective peak values in the fourth quarter of 2003. Based on this analysis, we do not see a meaningful difference in discharge volume trends across payer type.

**Figure Four: Annualized Medicare Impact, 4 Trailing Quarters**

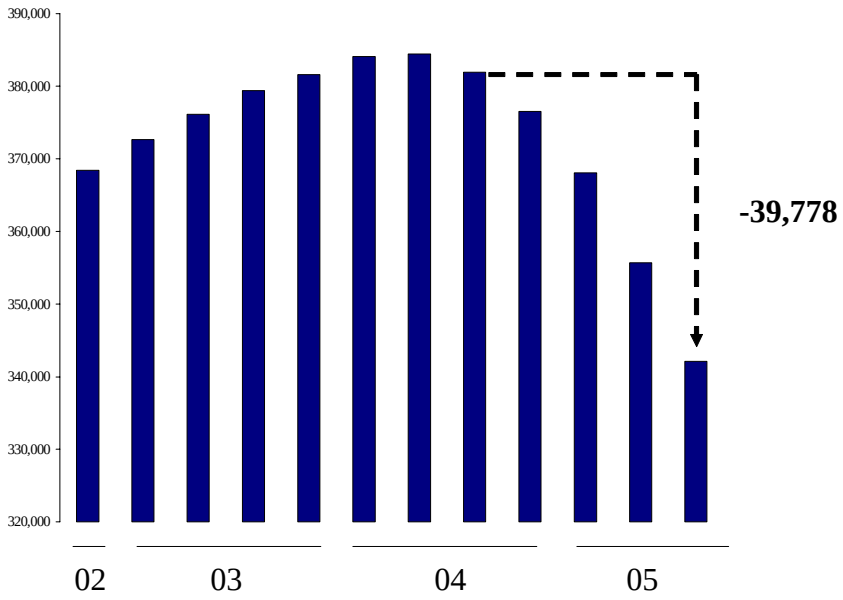


Figure Four shows the impact of these trends on annualized program volume in Medicare. In each quarter, the bar value represents the sum of Medicare discharges in that quarter plus the three preceding quarters, in order to present an "annual equivalent" picture of the trend. Viewed on this basis, the observed run rate in the last four quarters represents a decline of nearly 40,000 discharges relative to the preceding four quarter period. Since our data set comprises approximately 77% of the total Medicare volume estimated by CMS, generalizing our data to the universe would imply an overall caseload decline of approximately 52,000 cases.

The run rate for Q III 2005, which is the first quarter of the 2006 program year, is nearly 16,000 discharges fewer than Q III 2004, the first quarter of the 2005 program year. If this rate represents a new equilibrium, it would imply an annual level of discharges in the range of 64,000 fewer cases in program year 2006 than in 2005. However, we have no evidence to suggest that such a new equilibrium has been reached. It is possible that the number of IRF discharges will increase in future quarters—or fall at an even greater rate—in which case the annual drop in discharges for program year 2006 would be even more pronounced.

Trends by Diagnostic Type

Table One presents our analysis of the shift in volume by Rehabilitation Impairment Code. The table shows a comparison of the quarterly volume in the second quarter of 2003, when the CMS proposed rule detailing its intentions was published, and the third quarter of 2005, the last quarter for which we have data.

**Table One: Discharge Changes by RIC Category**

| RIC | Descriptor | Q II: 03 | Q III : 05 | Difference |
|---|---|---|---|---|
| 08 | Lower Extremity Joint Replacement | 33,098 | 23,214 | -9,884 |
| 20 | Miscellaneous | 14,875 | 9,918 | -4,957 |
| 14 | Cardiac | 6,649 | 3,765 | -2,884 |
| 15 | Pulmonary | 2,657 | 1,171 | -1,486 |
| 12 | Osteoarthritis | 2,046 | 626 | -1,420 |
| 16 | Pain Syndrome | 2,891 | 1,671 | -1,220 |
| 09 | Other Orthopedic | 6,762 | 5,556 | -1,206 |
| 01 | Stroke | 23,527 | 22,944 | -583 |
| 13 | Rheumatoid and Other Arthritis | 1,125 | 720 | -405 |
| 05 | Spinal Cord Dysfuction, Non-Traumatic | 5,308 | 5,047 | -261 |
| 11 | Amputation, Non-Lower Extremity | 377 | 186 | -191 |
| 17 | MMT without Brain/Spinal Cord Injury | 2,830 | 2,802 | -28 |
| 19 | Guillain-Barre | 382 | 417 | 35 |
| 21 | Burns | 233 | 294 | 61 |
| 10 | Amputation, Lower Extremity | 3,645 | 3,814 | 169 |
| 07 | Lower Extremity Fracture | 13,675 | 13,878 | 203 |
| 18 | MMT with Brain/Spinal Cord Injury | 1,531 | 1,777 | 246 |
| 04 | Spinal Cord Dysfunction, Traumatic | 1,678 | 1,994 | 316 |
| 06 | Neurological Conditions | 5,509 | 6,423 | 914 |
| 03 | Brain Dysfunction, Non-Traumatic | 3,955 | 4,937 | 982 |
| 02 | Brain Dysfunction, Traumatic | 3,382 | 4,460 | 1,078 |
| Total | | 136,135 | 115,614 | -20,521 |

*Moran Company Analysis of Data Furnished by UDS $_{MR}$ and eRehabData®*

From the evidence available, we do not believe it is possible to judge whether these caseload declines represent achievement of a new equilibrium, or whether further declines in caseload can be expected.

Summing up, the conclusions we draw from this analysis are as follows:

- Immediately following implementation of the new enforcement regime in the Final Rule of May, 2004, the prior growth trend in IRF discharges ended, and volume has declined steadily over the ensuing five quarters.

- In the first three quarters of 2005, the downtrend, which affects all payers, is equivalent to a -16.0% annualized decline.

- This decline is not uniform across all diagnostic categories; five diagnostic categories out of 22 explain more than the entire decline in caseload from Q II 03 to Q III 05.

- These diagnostic categories are those which CMS has indicated, in the preambles to the proposed and final rules, to be likely to be subject to the most scrutiny under the new enforcement policy.

- Given the correlation between the stated policy and the concentrated impact of the caseload decline, it is difficult to reach the conclusion that this is a coincidence.

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**Inpatient Rehabilitation Discharges by Rehabilitation Impairment Category (RIC)**
**Combined Data (N=746)**
**All Payers**

| RIC | | 2002 | | | | 2003 | | | | 2004 | | | | 2005 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 |
| 01 | Stroke | 23,137 | 23,946 | 23,344 | 23,359 | 23,147 | 23,527 | 23,049 | 23,190 | 23,266 | 22,982 | 22,908 | 23,099 | 23,867 | 24,075 | 22,944 |
| 02 | Brain Dysfuction, Traumatic | 3,072 | 3,310 | 3,407 | 3,521 | 3,180 | 3,382 | 3,700 | 3,694 | 3,379 | 3,721 | 4,123 | 4,175 | 3,906 | 4,051 | 4,460 |
| 03 | Brain Dysfuction, Non-Traumatic | 3,552 | 3,790 | 3,707 | 3,822 | 3,822 | 3,955 | 3,908 | 4,049 | 4,231 | 4,308 | 4,494 | 4,467 | 4,757 | 5,175 | 4,937 |
| 04 | Spinal Cord Dysfuction, Traumatic | 1,518 | 1,662 | 1,873 | 1,840 | 1,601 | 1,678 | 1,902 | 1,867 | 1,632 | 1,724 | 1,967 | 1,997 | 1,676 | 1,784 | 1,994 |
| 05 | Spinal Cord Dysfuction, Non-Traumatic | 4,733 | 5,072 | 4,923 | 5,185 | 4,998 | 5,308 | 5,456 | 5,602 | 5,086 | 5,422 | 5,523 | 5,450 | 5,137 | 5,247 | 5,047 |
| 06 | Neurological Conditions | 5,231 | 5,319 | 5,263 | 5,313 | 5,220 | 5,509 | 5,728 | 5,677 | 5,796 | 6,008 | 6,058 | 6,164 | 6,508 | 6,422 | 6,423 |
| 07 | Lower Extremity Fracture | 12,648 | 12,754 | 13,095 | 13,409 | 13,947 | 13,675 | 13,724 | 14,496 | 14,439 | 13,943 | 13,862 | 14,565 | 14,375 | 14,216 | 13,878 |
| 08 | Lower Extremity Joint Replacement | 28,180 | 30,672 | 30,522 | 32,901 | 30,571 | 33,098 | 32,416 | 34,461 | 31,484 | 33,651 | 30,842 | 31,582 | 27,307 | 26,084 | 23,214 |
| 09 | Other Orthopedic | 5,551 | 5,978 | 6,150 | 6,778 | 6,639 | 6,762 | 6,754 | 6,867 | 6,904 | 7,003 | 6,676 | 6,817 | 6,378 | 5,852 | 5,556 |
| 10 | Amputation, Lower Extremity | 3,507 | 3,680 | 3,692 | 3,410 | 3,526 | 3,645 | 3,715 | 3,528 | 3,583 | 3,765 | 3,658 | 3,577 | 3,528 | 3,711 | 3,814 |
| 11 | Amputation, Non-Lower Extremity | 326 | 440 | 368 | 303 | 345 | 377 | 404 | 375 | 368 | 332 | 273 | 247 | 221 | 217 | 186 |
| 12 | Osteoarthritis | 2,113 | 1,989 | 1,939 | 1,938 | 1,951 | 2,046 | 1,880 | 1,665 | 1,498 | 1,623 | 1,207 | 897 | 767 | 764 | 626 |
| 13 | Rheumatoid and Other Arthritis | 1,017 | 1,087 | 1,030 | 1,124 | 1,030 | 1,125 | 1,139 | 1,186 | 1,141 | 1,044 | 893 | 832 | 764 | 723 | 720 |
| 14 | Cardiac | 6,274 | 6,567 | 6,126 | 6,608 | 6,650 | 6,649 | 6,241 | 6,467 | 6,574 | 6,360 | 5,692 | 5,551 | 4,963 | 4,383 | 3,765 |
| 15 | Pulmonary | 3,565 | 2,957 | 2,203 | 2,349 | 2,777 | 2,657 | 2,040 | 2,284 | 3,151 | 2,419 | 1,710 | 1,641 | 2,387 | 1,751 | 1,171 |
| 16 | Pain Syndrome | 2,546 | 2,827 | 2,783 | 3,054 | 2,794 | 2,891 | 2,717 | 2,610 | 2,511 | 2,492 | 2,491 | 2,352 | 1,837 | 1,804 | 1,671 |
| 17 | MMT without Brain/Spinal Cord Injury | 2,317 | 2,677 | 3,017 | 2,989 | 2,803 | 2,830 | 3,112 | 3,011 | 2,693 | 2,865 | 2,794 | 2,739 | 2,330 | 2,477 | 2,802 |
| 18 | MMT with Brain/Spinal Cord Injury | 1,191 | 1,454 | 1,661 | 1,729 | 1,378 | 1,531 | 1,812 | 1,745 | 1,499 | 1,645 | 1,864 | 1,879 | 1,357 | 1,651 | 1,777 |
| 19 | Guillain-Barre | 419 | 401 | 396 | 382 | 446 | 382 | 409 | 418 | 430 | 402 | 362 | 337 | 419 | 458 | 417 |
| 20 | Miscellaneous | 13,529 | 13,828 | 14,167 | 14,938 | 15,552 | 14,875 | 14,619 | 14,829 | 15,985 | 14,897 | 13,949 | 13,226 | 12,579 | 10,941 | 9,918 |
| 21 | Burns | 194 | 235 | 208 | 221 | 221 | 233 | 215 | 233 | 238 | 258 | 256 | 214 | 209 | 265 | 294 |
| | Total | 124,620 | 130,645 | 129,874 | 135,173 | 132,598 | 136,135 | 134,940 | 138,254 | 135,888 | 136,864 | 131,602 | 131,808 | 125,272 | 122,051 | 115,614 |

*Moran Company Analysis of Data Furnished by UDS $_{MR}$ and eRehabData ®*

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**Inpatient Rehabilitation Discharges by Rehabilitation Impairment Category (RIC)**
**Combined Data (N=746)**
**Medicare**

| | | 2002 | | | | 2003 | | | | 2004 | | | | 2005 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 | Q4 | Q1 | Q2 | Q3 |
| 01 | Stroke | 16,071 | 16,476 | 16,036 | 15,863 | 15,792 | 15,956 | 15,564 | 15,571 | 15,656 | 15,326 | 15,209 | 15,267 | 15,751 | 16,076 | 15,042 |
| 02 | Brain Dysfuction, Traumatic | 1,195 | 1,294 | 1,219 | 1,316 | 1,309 | 1,323 | 1,384 | 1,429 | 1,459 | 1,554 | 1,528 | 1,747 | 1,707 | 1,771 | 1,711 |
| 03 | Brain Dysfuction, Non-Traumatic | 1,878 | 1,956 | 1,973 | 2,010 | 1,977 | 2,090 | 2,012 | 2,137 | 2,241 | 2,274 | 2,374 | 2,395 | 2,645 | 2,762 | 2,693 |
| 04 | Spinal Cord Dysfuction, Traumatic | 510 | 558 | 561 | 526 | 479 | 541 | 551 | 510 | 521 | 559 | 586 | 582 | 514 | 556 | 555 |
| 05 | Spinal Cord Dysfuction, Non-Traumatic | 2,948 | 3,255 | 3,145 | 3,243 | 3,202 | 3,353 | 3,569 | 3,611 | 3,207 | 3,487 | 3,522 | 3,454 | 3,246 | 3,301 | 3,117 |
| 06 | Neurological Conditions | 3,808 | 3,861 | 3,720 | 3,853 | 3,713 | 3,974 | 4,063 | 4,032 | 4,136 | 4,298 | 4,415 | 4,584 | 4,781 | 4,649 | 4,682 |
| 07 | Lower Extremity Fracture | 10,687 | 10,712 | 10,876 | 11,267 | 11,598 | 11,444 | 11,443 | 12,148 | 12,072 | 11,600 | 11,537 | 12,079 | 11,985 | 11,800 | 11,525 |
| 08 | Lower Extremity Joint Replacement | 20,195 | 21,662 | 21,707 | 23,087 | 21,547 | 23,233 | 22,889 | 24,422 | 22,293 | 23,993 | 22,391 | 22,674 | 19,669 | 18,580 | 16,812 |
| 09 | Other Orthopedic | 4,226 | 4,443 | 4,572 | 5,100 | 4,990 | 5,107 | 5,081 | 5,212 | 5,200 | 5,328 | 5,082 | 5,117 | 4,760 | 4,323 | 4,073 |
| 10 | Amputation, Lower Extremity | 2,546 | 2,543 | 2,588 | 2,345 | 2,401 | 2,529 | 2,528 | 2,371 | 2,431 | 2,629 | 2,545 | 2,330 | 2,416 | 2,482 | 2,538 |
| 11 | Amputation, Non-Lower Extremity | 244 | 310 | 277 | 218 | 248 | 273 | 290 | 260 | 256 | 242 | 193 | 177 | 168 | 148 | 121 |
| 12 | Osteoarthritis | 1,871 | 1,750 | 1,690 | 1,677 | 1,705 | 1,761 | 1,669 | 1,446 | 1,319 | 1,410 | 1,056 | 813 | 691 | 673 | 561 |
| 13 | Rheumatoid and Other Arthritis | 846 | 906 | 838 | 922 | 838 | 923 | 914 | 972 | 930 | 815 | 693 | 644 | 600 | 554 | 536 |
| 14 | Cardiac | 5,452 | 5,774 | 5,330 | 5,777 | 5,778 | 5,817 | 5,454 | 5,661 | 5,772 | 5,560 | 4,933 | 4,838 | 4,345 | 3,783 | 3,234 |
| 15 | Pulmonary | 3,041 | 2,457 | 1,829 | 1,943 | 2,314 | 2,200 | 1,716 | 1,925 | 2,665 | 2,022 | 1,446 | 1,362 | 1,993 | 1,425 | 949 |
| 16 | Pain Syndrome | 1,944 | 2,122 | 2,065 | 2,292 | 2,089 | 2,171 | 2,058 | 1,964 | 1,926 | 1,891 | 1,865 | 1,797 | 1,421 | 1,408 | 1,281 |
| 17 | MMT without Brain/Spinal Cord Injury | 951 | 1,057 | 1,037 | 1,133 | 1,053 | 1,043 | 1,071 | 1,049 | 1,004 | 971 | 918 | 900 | 797 | 766 | 864 |
| 18 | MMT with Brain/Spinal Cord Injury | 200 | 195 | 210 | 252 | 214 | 237 | 216 | 250 | 231 | 231 | 226 | 265 | 222 | 220 | 213 |
| 19 | Guillain-Barre | 141 | 151 | 127 | 107 | 161 | 126 | 135 | 143 | 142 | 130 | 122 | 115 | 135 | 142 | 142 |
| 20 | Miscellaneous | 10,927 | 10,986 | 11,361 | 11,950 | 12,487 | 11,869 | 11,812 | 11,981 | 12,910 | 11,996 | 11,259 | 10,553 | 10,068 | 8,520 | 7,722 |
| 21 | Burns | 65 | 73 | 47 | 52 | 67 | 60 | 47 | 58 | 74 | 66 | 52 | 45 | 70 | 69 | 52 |
| | Total | 89,746 | 92,541 | 91,208 | 94,933 | 93,962 | 96,030 | 94,466 | 97,152 | 96,445 | 96,382 | 91,952 | 91,738 | 87,984 | 84,008 | 78,423 |

*Moran Company Analysis of Data Furnished by UDS $_{MR}$ and eRehabData®*