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October 8, 2021

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The Honorable Chiquita Brooks-LaSure
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Submitted electronically via www.reginfo.gov and www.regulations.gov

Re: Comments on Proposed Review Choice Demonstration for Inpatient Rehabilitation Facility Services (CMS-10765)

The American Academy of Physical Medicine & Rehabilitation (AAPM&R or “the Academy”) represents front-line physicians with expertise in medical rehabilitation who routinely assess Medicare beneficiaries with serious injuries, illnesses, and conditions and render clinical decisions on their admission to inpatient rehabilitation hospitals and units or, when appropriate, other settings of post-acute care. Consistent with our comments submitted on February 16, 2021, on the proposed Review Choice Demonstration for IRF care, *we implore you to withdraw this demonstration project, rethink this approach to ensuring accuracy and integrity of IRF admissions, and thereby preserve access to necessary patient medical and rehabilitative care while limiting the burden physicians face with widespread audits of their IRF admission decisions.*

AAPM&R is the national medical specialty organization representing more than 9,000 physicians who are specialists in physical medicine and rehabilitation (PM&R). PM&R physicians, also known as “physiatrists,” are medical experts in a wide variety of conditions that affect nearly every organ system including, but not limited to, the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disabilities, and are experts in designing comprehensive, interdisciplinary, patient-centered treatment plans.



Physiatrists utilize cutting-edge as well as time-tested treatments to maximize recovery, functional status, and quality of life.

Maintaining high quality care in free-standing inpatient rehabilitation hospitals and rehabilitation units in acute care hospitals (collectively referred to as “inpatient rehabilitation facilities” or IRFs) is a significant priority to AAPM&R members. Rehabilitation physicians are equipped with the medical expertise required to lead the interdisciplinary care team in the comprehensive medical management and rehabilitation care of vulnerable patients with highly complex needs who comprise the typical patient population in IRFs. Physiatrists have a well-established clinical and leadership role in IRFs.

By virtue of their extensive training and expertise in medicine, rehabilitation, management of comorbid conditions, and optimizing function, physiatrists commonly serve as IRF medical directors and as the primary admitting physicians in these facilities. Appropriately, physiatrists are also typically the designated leader of the patient’s interdisciplinary rehabilitation care team in this setting. As such, physiatrists direct and supervise intensive rehabilitation programs, while exercising their clinical expertise in the comprehensive medical management of comorbid conditions and rehabilitative care of this complex patient population. IRFs are a primary setting for physical medicine and rehabilitation education and training, passing on to generations of future rehabilitation physicians the skills and expertise necessary to treat this vulnerable Medicare population.

I. Academy Reaction to CMS Announcement of IRF Review Choice Demonstration

The Academy submitted comments strongly opposing the first version of the “Review Choice Demonstration” (RCD) for IRFs in February 2021 and cannot hide our disappointment that the Centers for Medicare and Medicaid Services (CMS) chose to largely ignore our comments, as well as the comments of 34 out of 35 commentors received from the public about CMS 10765. CMS seems intent on plowing forward with “cutting and pasting” a home health audit demonstration model designed to address documentation deficiencies to a much more complex IRF setting where fundamental disagreements involving medical necessity of admissions are at issue. This is particularly abhorrent during a pandemic in which physiatrists are serving on front-lines, including in IRFs.

The current IRF RCD proposes to subject selected IRFs in 17 states, three U.S. territories, and the District of Columbia (upon full implementation) to 100% pre-claim or post-payment review of IRF admissions. This is an unprecedented nationwide audit that is stunning in scope. CMS' approach to this proposed audit will bar the door to IRF care for certain patients the government and its contractors deem unworthy of intensive, coordinated, interdisciplinary rehabilitation care provided in IRFs, regardless of the judgement and expertise of the admitting physician evaluating these patients. Worse yet is that patients in need of intensive rehabilitation will be hard pressed to find access to it in skilled nursing facilities or through home health agencies, now that these payment systems have been modified to deemphasize rehabilitation therapies through implementation of the Patient Driven Payment Model and the Patient Driven Groupings Model, respectively.¹

It is not hyperbole to say that the current version of the RCD for IRFs is an affront to the field of psychiatry, a broadside attack on an entire physician specialty, and an assertion that CMS and its contractors know better how to treat patients in the Medicare system with severe medical and functional needs than physicians with specialized knowledge of rehabilitation medicine who make real-time clinical judgments after physically assessing patients who are referred to IRFs for admission. It is one of the clearest cases of CMS and its contractors intending to practice medicine and will send a chill across all health care providers who could be the next set of providers to incur this level of unjustified scrutiny. 100% claim review of IRF admissions across roughly half the country constitutes a dragnet fishing expedition based not on fraud, as CMS asserts, but on fundamental disagreements of medical necessity that have persisted for years and will materially risk

¹ Early data on PDPM implementation demonstrate the potential risks associated with untested payment reforms that could result in significant harm to PAC patients. Specifically, data suggest that Medicare beneficiaries may be experiencing challenges accessing rehabilitation services under these payment systems, while PAC providers inappropriately benefit from excessive payments. For example, CMS noted in its final FY 2022 SNF payment rule that the implementation of the PDPM in FY 2020 resulted in an unintended increase in payments of approximately 5% in FY 2020, as compared to the prior payment model (RUGIV); if CMS were to apply a parity adjustment for FY 2022 to account for such overpayments, CMS estimated that payments to SNFs would decrease by \$1.7 billion. CMS' analysis also found that therapy minutes decreased from approximately 91 therapy minutes per day in FY 2019 to 62 minutes in FY 2020. CMS points out that this 30% drop in minutes was "well before the onset of the pandemic." CMS also pointed out that in addition to the decrease in therapy minutes, there was a decrease in individualized modes of therapy.

patient harm by categorically denying certain patients under Medicare coverage access to a level of medical care to which they are entitled.

Admission decisions to inpatient hospital rehabilitation are not made by institutions. They are made by treating rehabilitation physicians, most of whom are not employed by the hospital itself. These treating physicians have specialized education and training in rehabilitation medicine, often possess board certification in physical medicine and rehabilitation, and in many instances have years of experience in treating the rehabilitation needs of at-risk populations. These patients include those with spinal cord injury, brain injury, stroke, limb amputation, neurological disorders, and, more recently, debility from the ravages of COVID-19, to name a few common examples of IRF patients.

In 2010, CMS completely revised IRF regulations to reset medical necessity criteria for admission and created an extensive set of documentation requirements that placed tremendous responsibility for admission decisions on rehabilitation physicians. These regulations were intended to create objective standards and decrease the number of denied claims.² These regulations emphasize process, the admitting physician's judgment, and the importance of documentation. IRF coverage is supposed to be determined "at the time of the patient's admission," based on a rehabilitation physician's reasonable expectations regarding the patient's need for intensive, multidisciplinary therapy services under the supervision of the rehabilitation physician, and with the assistance of an interdisciplinary care team, to participate in and achieve a significant benefit from those therapy services.³

The denials the IRF field has seen since implementation of the 2010 regulations largely centered on documentation compliance, which were commonly referred to as "technical" denials. More recently, as providers have achieved compliance with the documentation requirements, government auditors have focused on "medical necessity," allowing largely non-physician auditors to override the medical decisions of treating rehabilitation physicians based on their subjective perception of "medical necessity" for a patient they have never met.

IRF denials in the past several years have been based on more than just differing interpretations of the regulations and guidance documents,

² Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2010, 74 Fed. Reg. 39,762 (Aug. 7, 2009); 42 C.F.R. § 412.600 *et seq.*

³ 42 C.F.R. § 412.622(a)(3); MBPM, ch. 1, § 110.2.

represented by the Medicare Benefits Policy Manual (MBPM), a non-binding document that contractors often mistakenly rely on to deny IRF claims. IRF denials also stem from standards of admission that are not reflected in the regulatory requirements, such as contractor assertions that the patient “could have been treated in a less intensive setting,” a standard which was specifically rejected through the public notice and comment process when the 2010 regulations were promulgated. In fact, we are aware of some Medicare Administrative Contractor (MAC) reviewers who scan the clinical record of each patient file looking specifically for evidence to confirm this fallacious standard.

CMS explicitly disavowed the “less intensive setting” standard in a national conference call on November 12, 2009.⁴ In that call, Dr. Susanne Seagrave, the Inpatient Rehabilitation Team Leader in the Division of Institutional Post-Acute Care at the time, displayed a slide discussing the new coverage criteria, and Dr. Seagrave stated:

“Notice that nowhere on the slide and nowhere in this presentation are we going to talk about whether the patient could have been treated in a skilled nursing facility or another setting of care. Under the new requirements, a patient meeting all of their required criteria for admission to an IRF would be appropriate for IRF care whether or not he or she could have been treated in a skilled nursing facility.”⁵

The current IRF coverage regulation emphasizes the physician’s judgment when admitting a patient to an IRF and does not create black-and-white coverage rules that can be applied mechanically by auditors. The regulation acknowledges that the decision to admit a patient to an IRF is a *complex medical judgment by the rehabilitation physician*. The physician makes this decision not just by reviewing paper records but, in many instances, by directly examining the patient. Sometimes, the rehabilitation physician has treated the patient previously and is familiar with the patient’s medical history. **A strictly paper review, after the fact, cannot replicate the depth of experience of the rehabilitation physician who actually places hands on the patient and makes decisions in real time.**

⁴ See Transcript and Audio File of IRF PPS Coverage Requirements National Provider Conference Call (Nov. 12, 2009), <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Coverage.html>.

⁵ See *id.* at 7.

Rehabilitation physicians admitting Medicare beneficiaries to IRFs grapple daily with real-life decision-making where socio-economic, familial, and demographic factors come into play. Medically managing this compromised patient population while providing an intensive course of rehabilitation therapy, providing education to the patient and the patient's family on their new condition(s), and delivering high quality outcomes is extremely challenging and requires the extensive resources an inpatient rehabilitation hospital provides. IRF treating physicians often reject a large percentage of patient referrals because the patients fail to meet the very strict criteria for admission. The proposed RCD seems to completely ignore the very process set in place by CMS itself to ensure that the right patients are admitted to this specialized setting of care.

In addition, under CMS' RCD proposal, one of the most regulated settings of post-acute care, IRFs, will require even more time and attention from treating physicians to document medical necessity, engage in discussions with MACs to obtain pre-claim approval, and challenge post-payment claim denials based on medical necessity before Administrative Law Judges (ALJs). This will further add to physician burden and burn-out in this vitally important setting of post-acute care.⁶

The RCD is very likely to produce a "gatekeeper" effect that will result in inappropriate denials of IRF admission for potentially tens of thousands of Medicare beneficiaries over the course of the five-year demonstration. Without an expeditious appeals system, where a neutral third-party adjudicator can resolve medical necessity disputes, rehabilitation physicians will be placed in the unenviable position of either denying IRF admission to patients they believe meet the medical necessity criteria or continuing to accept such patients and placing their IRFs at serious financial risk over time if these stays are denied. This demonstration, therefore, has the effect of CMS and its contractors practicing medicine by superseding the medical judgment of the treating rehabilitation physician. Instead, these Medicare beneficiaries will wind up in other, less appropriate settings where their conditions could be inadequately treated, their long-term outcomes

⁶ Medscape National Physician Burnout, Depression & Suicide Report 2019, Medscape, January 16, 2019. Retrieved from: https://www.medscape.com/slideshow/2019-lifestyle-burnout-depression-6011056?src=WNL_physrep_190116_burnout2019&uac=306605AJ&impID=1861588&faf=1#3 (finding psychiatrists ranked as the third-most burnt out specialty among the 50 ranked specialties, with 52% of reporting psychiatrists feeling burnt out. The average percentage of burnout for all physician specialties was 44%).

compromised, and their likelihood of acute care hospital readmission increased. Additionally, some patients will end up unnecessarily spending more time in acute care, increasing their risk of complications from an unnecessary hospital stay and reducing access to other patients who may need hospital admission.

The RCD in its current form has the potential to fundamentally alter the Medicare IRF benefit by curtailing coverage for those patients that MACs believe are not appropriate for admission. There is little doubt that, over time, this will restrict coverage in this setting compared to admission standards and the standard of care in place today. In fact, that appears to be the ultimate goal of the RCD program. Rather than being transparent, publicly proposing to restrict IRF coverage, and enduring public scrutiny through notice and comment rulemaking, CMS is asking its contractors to do the heavy lifting for it, under the cover of increased auditing to combat unsubstantiated fraud allegations, when what is truly in play is subjective interpretations and adherence to inapplicable and non-binding standards of IRF admission.

A sterile policy debate about the reasonableness and necessity of inpatient rehabilitation hospital care fails to recognize the personal impact these admission decisions have on people with Medicare coverage and their families. When a father has a stroke; when a mother falls and fractures her hip; when a son sustains a head injury in a car accident; when a sister develops chronic, progressive Multiple Sclerosis; when a best friend is seriously degraded by a lengthy ICU stay due to COVID-19: what is the setting of care loved ones would insist upon for their medical and rehabilitative care?

IRF care is, in fact, highly effective. Outcomes for most conditions in IRFs are significantly better than in lower-intensity levels of care, such as skilled nursing facilities (SNFs). When compared to similar patients who received rehabilitation in SNFs, IRF patients had better long-term clinical outcomes, returned home earlier, remained home longer, visited the emergency room less frequently, were often less likely to be readmitted to the hospital, and lived longer.⁷ This is why evidence-based guidelines categorically recommend that certain patients with particular critical diagnoses receive

⁷ Dobson DaVanzo & Assocs., LLC, *Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities (IRFs) and After Discharge*, E-3 (2014), <https://www.sutterhealth.org/pdf/services/physical-therapy-rehabilitation/patient-outcomes-of-irf-vs-snf.pdf>.

immediate IRF care. For example, the American Heart Association and the American Stroke Association recommend IRF care for all stroke patients.⁸

CMS suggests that, like the home health RCD, the IRF community will come to appreciate and even welcome these audits over time because they will increase payment certainty. We can state with great confidence that this will not be the case. CMS's view clearly illustrates the disconnect between the home health RCD, which is focused on improved documentation, and the IRF RCD, which is focused on medical necessity. A professional environment where rehabilitation physicians will be second-guessed by CMS' contractors on every IRF admission they approve, leading to a debate and a need to justify every case that is denied is a recipe for disaster that will not end in rehabilitation physicians embracing the program.

AAPM&R therefore reiterates our outright opposition to the design and scope of the proposed RCD demonstration project and, once again, strongly urges CMS to withdraw this proposal. Below, we highlight and elaborate on some of the points we stressed in our February response to the first version of the RCD program. The Academy does not believe CMS adequately considered our legitimate concerns with the RCD approach and hereby requests that CMS reconsider our points and accommodate the needs of treating rehabilitation physicians and their patients if CMS proceeds with any version of the RCD program in the future.

As we offered in February, and several times over the past three years, AAPM&R would welcome the opportunity to work with CMS and other relevant stakeholders to create clearer guidelines for the qualifications of a rehabilitation physician, the person often in the position to admit patients to IRF care. Ensuring these qualifications are adequate instead of the current vague standard of "specialized experience in rehabilitation," will help ensure appropriate patients who have potential to succeed in IRFs are admitted.

II. Standard for Review of IRF Claims

Before CMS embarks on a massive five-year audit of IRF claims across the country, AAPM&R cannot stress enough how important it is to have senior program integrity officials and its contract medical reviewers hold a series of

⁸ See William J. Powers, et al., *2018 Guidelines for the Early Management of Patients with Acute Ischemic Stroke: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association*, 49 *STROKE* e46 (2018), <http://stroke.ahajournals.org/content/49/3/e46>.

meetings with practicing rehabilitation physician leaders to discuss real IRF cases and explore medical necessity of IRF admissions to gain a better understanding of mutual expectations of appropriate patients to be treated in this setting. Despite that the IRF setting is among the most highly regulated of any post-acute care provider type, the fact is that subjective factors and clinical judgment continue to play an appropriate key role in admission decisions.

In the wake of the 2018 Office of Inspector General (OIG) report No. A-01-15-00500,⁹ the Academy as well as the American Medical Rehabilitation Providers Association (AMRPA) and the Federation of American Hospital (FAH) met with OIG to discuss this report. After a Freedom of Information Act (FOIA) request was filed by AMRPA for the patient files associated with this 220-case sample, OIG agreed to reveal the patient files of 10 cases—with appropriate HIPAA protections in place—involved in that audit for the purpose of having a series of clinical meetings to attempt to gain a better understanding of the various perspectives of medical reviewers, both from the perspective of the government and from the IRF field.

COVID-19 diverted attention away from this project but, recently, OIG officials agreed to meet with a panel of seven physicians from the IRF field to discuss seven patient cases from this audit, again, for the purpose of trying to attain a better understanding on the factors that favor admission verses non-admission to an IRF setting of care. This meeting is expected to occur once the OIG's new IRF audit contractor is in place, approximately at the beginning of 2022. *We strongly urge CMS to host a series of similar meetings with these same IRF physicians to discuss these same seven IRF patients.* All medical reviewers contracted by CMS with authority to override the decisions of admitting IRF physicians should be required to participate in these meetings. This would provide a real-life set of illustrative cases where the merits of each case can be clinically assessed and debated. In fact, participation—or at least observation—of these meetings should be a required component of contract reviewer training prior to the commencement of any IRF audits under the RCD project.

III. Additional Constructive Proposals CMS Should Consider

Following publication of the same 2018 OIG report, these same three

⁹ OIG, U.S. Dep't of Health & Human Servs., No. A-01-15-00500, Many Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements (2018) (hereinafter "IRF OIG Report").

organizations also developed a set of constructive proposals to address some of the OIG's most serious concerns. For instance, these proposals included the following recommendations:

- Create a Medical Rehabilitation Advisory Committee, compliant with the Federal Advisory Committee Act (FACA), that would advise CMS and its contractors on post-acute care issues including evidence-based medical necessity standards.
- Disclose CMS' Auditor Instructions and Guidelines and meet with IRF stakeholders to discuss the standards used by contractors to assess the medical necessity of IRF claims. This heightened level of transparency is critical to the credibility of the RCD initiative, which seeks to dramatically expand the auditing process for IRFs.
- Standardize Error Rate Calculations across contractors such as the Targeted Probe and Educate (TPE) program, the Comprehensive Error Rate Testing (CERT) contractors, and any MACs that review IRF claims, including RCD contractors. Greater transparency and consistency in error rate calculation standards and procedures would help providers comply with Medicare requirements.
- Require CMS Contractors to Hold Forums with IRF Stakeholders to ensure dialogue and communication during IRF audits. Routine communication and feedback from the field will help contractors and CMS closely monitor this program and make modifications to it as problems arise.

To our knowledge, CMS did not adopt any of these proposals, all of which, we believe, could help alleviate some of the discord between CMS, its contractors, and the IRF field. We urge CMS now to revisit these proposals and adopt as many of them as possible as it seeks to dramatically increase auditing in the IRF space.

IV. Limit the Stunning Scope of the RCD and Implications for Other Providers

CMS' intention to subject all rehabilitation hospitals within the jurisdiction of four regional MACs to 100% claim review regardless of their track records with previous audits is a stunning overreach of its authority and a warning shot to other provider settings that this magnitude of medical second-guessing from the federal government is the future of the Medicare program. As we stated in our February 2021 comment letter, this is tantamount to CMS practicing medicine by allowing its contractors' clinical staff to supersede the medical judgment of hundreds of trained and

experienced rehabilitation physicians as they interact daily with severely compromised Medicare beneficiaries. 100% claim review of this scope and breadth is unprecedented and is simply not supported by a sufficient finding of “fraud” to justify this sweeping escalation of auditing activity.

We therefore restate our request made in our February 2021 comment letter for CMS to dramatically lower this percentage of claim review in this demonstration program. There are numerous methodologies to achieve CMS’ goals that create much less burden on rehabilitation physicians, IRF providers, and Medicare beneficiaries. For instance, a sampling of Medicare claims for participating hospitals should be sufficient to determine whether an individual facility has ongoing compliance concerns that should be addressed via more detailed review. MACs could also probe certain claims by requesting the pre-admission screening only of a sample of claims and, once reviewed, further request additional documentation of claims that do not clearly establish medical necessity without further consideration. These are reasonable ways to mitigate unnecessary burden while enabling CMS to achieve its program integrity goals. We are disappointed CMS did not meaningfully consider these approaches in its most recent iteration of the RCD proposal and urge the agency at this time to seriously reconsider 100% claim review.

V. Physician Burden and Paperwork Reduction Act Estimates

AAPM&R has long expressed our significant concerns with the outsized and unnecessary administrative burden placed on physicians in IRF settings. Far too much of a rehabilitation physician’s time in an IRF is spent documenting medical necessity and meeting arbitrary deadlines that often have little clinical relevance to the patient’s treatment. We are concerned that the proposed demonstration would present a significant additional documentation burden on IRF rehabilitation physicians. As part of the Paperwork Reduction Act, CMS is required to estimate the amount of time and costs associated with the effort by IRFs to respond to the audits under the RCD. As stated in our February comment letter, CMS vastly underestimates the amount of time, resources, and personnel that will be involved to respond to 100% review of IRF claims.

Specifically, CMS estimates that preparing documentation for an individual claim will take clerical staff an average of 30 minutes per claim. This is a gross miscalculation of burden on providers that seriously understates the amount of time and effort required for the physician to review the patient file and defend the medical necessity of each claim at

issue. In both the pre-claim and post-payment context, we anticipate that rehabilitation physicians, therapists, rehabilitation nurses, and clinical specialists—in addition to clerical staff—will be required to help prepare and submit documentation to defend each challenged claim either during the pre-claim approval process or throughout the three main stages of the administrative appeals process. This will further tax already overworked physicians and, worse, take away from their already-limited time actually treating their patients.

VI. Expertise and Training of Reviewers

The proposed demonstration project is premised on error rates identified by Medicare CERT contractors' reviews of IRF claims, as well as audits conducted by the Office of Inspector General, which used some of the same contractors to assess the medical necessity of IRF claims. In the past decade, the CERT's error rates for IRFs have fluctuated dramatically, despite a very stable regulatory IRF landscape, illustrating the arbitrariness of these reviews and a general lack of understanding by contract reviewers of rehabilitation medicine and the required standards of admission. CMS states in the most recent RCD documents that physicians will be involved in claims review, to augment the expertise of "trained nurse reviewers" and other clinicians. We view this as insufficient because only physicians with training and experience in rehabilitation should review IRF claims. Claims should not be reviewed by unqualified nurse auditors whose decisions are rubber stamped by a physician minimally "involved" in the process.

The IRF coverage requirements clearly state the need for a "rehabilitation physician" to direct IRF care, mandating a licensed physician with specialized training and experience in rehabilitation to make the determination on admission of and supervise care furnished to IRF patients. We see no reason that the same requirements should not apply to the reviewers who aim to supersede the judgments of treating rehabilitation physicians during either pre- or post-claim review for IRF admissions. *Any final demonstration should mandate that denials cannot be made without the express review and approval of an appropriately credentialed rehabilitation physician who meets all the requirements established in 42 C.F.R. § 412.622.*

Of the estimated \$114 million CMS plans to spend on the IRF RCD, we believe a cost-effective use of funds would be to invest heavily in training of physician reviewers. Training materials should be developed and

shared publicly with stakeholders for review and comment before implementation. CMS should mandate in contracts with MACs that all reviewers have appropriate credentials and recent, demonstrable expertise and experience in inpatient rehabilitation hospital care. Finally, CMS should instruct its contractors that, subject to the Supreme Court's decision in *Azar v. Allina*,¹⁰ all MAC reviewers must treat the MBPM as non-binding guidance, and non-compliance with the MBPM does not independently justify a claim denial.

VII. Timelines of Pre-Claim Reviews and Communication with Contractors

Restrictions on IRF admissions will be compounded by the length of time the proposed demonstration allows for pre-claim reviews to be determined. CMS offered a modest concession in the most recent version of the IRF RCD proposal by reducing from 10 business days to 5 business days the amount of time the MAC may take to determine whether a resubmitted claim denial is approved for pre-claim review. But given the relatively brief length of stay of IRF patients, this timeframe is still not workable. CMS should instead require a 24-hour decision by the MAC on any pre-claim determination of medical necessity, and then be bound by that determination which should bar further medical review of the claim.

We strongly urge CMS to also ensure that MAC reviewers are available beyond business hours, on weekends, and over holidays, just as clinician members of patient teams are. IRFs do not cease to operate outside of typical business hours, and it is critical that the MACs making decisions regarding the availability of patient care keep to the same schedule. In a world where every single patient is reviewed for medical necessity, a 24-hour turn-around on these decisions wherever the request falls on the weekly calendar is crucial.

Additionally, as we stated in our February 2021 comment letter, we believe it is absolutely necessary to develop specific procedures under this demonstration project to facilitate efficient and effective clinician-to-clinician communication on individual patient cases. For instance, upon an initial pre-claim denial and a request for additional information by the MAC's rehabilitation physician, a rehabilitation-physician-to-

¹⁰ *Azar v. Allina Health Servs.*, 139 S.Ct. 1804 (2019)

rehabilitation-physician conversation should be required before a second denial is issued for a particular patient. This would allow clarification of misunderstandings, explanation of documents, development of nuanced reasons for IRF admission, and discussions of other factors between rehabilitation physicians before these cases become subject to the lengthy backlog of the administrative appeals process. This face-to-face physician meeting requirement has a precedent in the “discussion period” that was included as part of the permanent Recovery Audit Contractor program.

VIII. Definition of Rehabilitation Physician

We restate our view expressed in our February 2021 comment letter that CMS should consider an alternative solution to ensuring Medicare dollars are appropriately and efficiently spent in IRFs. AAPM&R is concerned that the regulatory definition of an IRF rehabilitation physician is too broad, resulting in some physicians that are not sufficiently experienced or qualified in rehabilitation filling these roles. Due to the complex care provided in IRFs and the costly nature of treating these medically complex patients, it is the Academy’s position⁹ that it is imperative to ensure physiatrists are filling these positions and assessing who would best benefit from IRF care.

As stated several times throughout these comments, IRFs provide intensive, comprehensive, 24-hour interdisciplinary care to a patient population that is medically complex. IRF patients have suffered a wide variety of injuries, chronic illness, disabilities, and their associated comorbidities. These patients and the interdisciplinary team treating them need to account for these conditions, pace of treatment, associated risks, optimizing function, and discharging to a higher quality of life. As such, having an experienced rehabilitation expert determine which patients should be admitted to this level of care could help reduce disagreements between CMS, its contractors, and IRF physicians.

AAPM&R would be glad to work with CMS to create tighter regulatory standards for the role of rehabilitation physicians.

IX. Timing of the RCD Demonstration

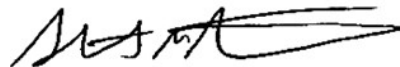
Aside from the serious, substantive concerns the Academy has with the merits of the RCD proposal, this is no time to implement a massive new audit program for IRF care. Physiatrists and IRFs have been—and continue to be—on the front lines of the COVID-19 public health

emergency (PHE). The waivers granted by Congress and CMS due to the PHE on the so-called 3-hour rule and 60% rule have been invaluable in permitting IRFs the flexibility to serve the immediate needs of their communities, including COVID-19 survivors who spent time in ICUs and on ventilators, but this also makes auditing of issues such as compliance with the intensity of therapy requirement impossible.

Physicians should not be required to spend critical hours compiling documentation and trying to convince Medicare contractors of the appropriateness of their IRF admission decisions at a time when all efforts are needed on the front lines of the pandemic. For this reason, CMS must refrain from embarking on any demonstration projects for a significant period of time once the PHE has been lifted.

For the foregoing reasons detailed in this letter, the Academy implores CMS to rethink the Review Choice Demonstration program for inpatient rehabilitation hospitals and units, *not* press forward with implementation of this severely flawed demonstration project, and thereby preserve access to patient care while limiting the burden physicians face with widespread audits of their IRF admission decisions. Thank you for your consideration of these comments. For more information, please contact Reva Singh, Director of Advocacy and Government Affairs at AAPM&R at rsingh@aapmr.org or 847.737.6030.

Sincerely,



Stuart M. Weinstein, MD
President, AAPM&R