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Department of Health and Human Services
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Mail Stop C4 – 26 – 05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically

Re: File Code CMS-1710-P
 Medicare Program; Inpatient Rehabilitation Facility Prospective
 Payment System for Federal Fiscal Year 2020

Dear Administrator Verma:

The American Academy of Physical Medicine and Rehabilitation (AAPM&R) thanks the Centers for Medicare & Medicaid Services (CMS) for the opportunity to offer comments on the proposed Inpatient Rehabilitation Facility (IRF) Prospective Payment System rule for fiscal year (FY) 2020. 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, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disability, and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life.

CMS’ proposals for care delivered in IRFs are of great interest to our members, who have a well-established clinical and leadership role in IRF settings. This was clearly demonstrated by the significant engagement of our members in response to this rule – particularly with respect to CMS’ proposal to weaken the definition of rehabilitation physician. As detailed further below, AAPM&R has significant concerns with this proposal, which we and many other stakeholders believe would harm the quality of care that patients in IRFs receive, increase



the risk of inefficient healthcare utilization, and raise significant program integrity concerns.

The Academy recognizes CMS efforts to remove burdensome requirements from the IRF regulations. We have alternative suggestions on certain regulations which we think would dramatically relieve some of the burden physicians face. Further information is provided below.

VII. Proposed Amendments to § 412.622 to Clarify the Definition of a Rehabilitation Physician

Overview

CMS proposes to revise the definition of rehabilitation physician in regulation text to specifically state that “Rehabilitation physician means a licensed physician **who is determined by the IRF** [emphasis added] to have specialized training and experience in inpatient rehabilitation.” Under this policy, CMS would not only discharge itself of its responsibility to hold IRFs accountable for ensuring that physicians who furnish care to IRF patients have specialized training and experience in inpatient rehabilitation, but also largely relinquish its authority to do so under proposed regulatory changes. As a result, AAPM&R has serious concerns that this proposal would harm the quality of care that patients in IRFs receive; increase the likelihood of improper or inefficient healthcare utilization; and raise significant program integrity concerns. For these and other reasons detailed below, *we urge CMS not to finalize its proposal to weaken the definition of rehabilitation physician at 42 CFR § 412.622. Rather, we request that CMS delay any changes to current regulations until stakeholders can develop a consensus approach for protecting the quality and integrity of IRF care.* AAPM&R believes such an approach must revisit and refine minimum qualifications of rehabilitation physicians.

Role of Psychiatrists in IRF Settings

As CMS is well aware, IRFs provide specialized, intensive care for patients with significant and complex rehabilitation needs who cannot be successfully treated and managed in other post-acute care settings. These can include patients with amputations, traumatic brain injury, spinal cord injury, stroke and many other illnesses and injuries. Appropriately, these patients are also required to meet specific eligibility criteria, including demonstrating their need for – and

the ability to benefit from – such intensive rehabilitation services, in order to ensure that Medicare resources are being utilized efficiently and effectively.

IRFs are required to provide hospital-level services, including 24-hour rehabilitation nursing. Additionally, IRFs provide a highly coordinated, interdisciplinary approach to rehabilitation care covering medicine, nursing, multiple therapy disciplines, and more. Under existing regulations, IRF patients must require an interdisciplinary team approach to care, as evidenced by weekly interdisciplinary team meetings. The interdisciplinary team meetings must implement appropriate treatment services; monitor and review the patient’s progress toward stated rehabilitation goals; identify any potential problems that could impede progress towards those goals; and where necessary, reassess goals and revise treatment plans for the patient. They must also be led by a rehabilitation physician.

Current regulations mandate that rehabilitation physicians must have specialized training and experience in inpatient rehabilitation, and they are also responsible for:

- Reviewing and concurring with findings of a comprehensive preadmission screening that demonstrates that a patient meets several criteria, including medical and rehabilitation needs;
- Completing a post-admission physician evaluation within 24 hours of a patient’s IRF admission;
- Developing an individualized overall plan of care for the patient; and
- Conducting face-to-face visits with patients at least 3 days per week throughout the patient stay to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient’s capacity to benefit from the rehabilitation process.

Most commonly, the role of the rehabilitation physician is filled by a PM&R specialist. Indeed, the American Medical Rehabilitation Providers Association (AMRPA) – a large national voluntary trade association representing rehabilitation providers – specifically notes that “the rehabilitation team is led by a physiatrist.”¹ Physiatrists gain unique experience and expertise during

¹ The AMRPA website includes the following language: “The hallmark of the inpatient rehabilitation hospitals and units is a highly integrated team approach to treatment. The rehabilitation team is led by a physiatrist, a board certified physician who specializes in physical medicine and rehabilitation (PM&R) and includes rehabilitation nurses, physical therapists, occupational therapists, speech language pathologists, psychologists and

their residency training that is not replicated in any other Accreditation Council of Graduate Medical Education (ACGME) program (e.g., design and prescription of prosthetics and orthotics, robotic and electronic mobility solutions, holistic treatment of pain syndromes, creation of comprehensive physical, occupational, and speech therapy plans of care for brain and spinal cord injuries, and much more). ***AAPM&R believes that this type of specialized training and expertise differentiates IRFs from other settings and maximizes the potential for patients to receive the most effective, high-value care possible in an IRF setting.***

At the same time, AAPM&R recognizes that other physicians may develop expertise in inpatient rehabilitation care through other routes besides PM&R residency training, for example through sub-specialization or fellowship training in related rehabilitation fields (e.g. spinal cord injury medicine, brain injury medicine, and neuromuscular medicine), and they may be sufficiently qualified for the rehabilitation physician role. Additionally, AAPM&R also acknowledges that other medical specialists, including physicians within the 24 specialties recognized by the American Board of Medical Specialties, also play an important role as consulting physicians who may be called to offer their expertise when medical complications arise for patients in IRFs. AAPM&R fully supports their ongoing engagement in IRF patient care and understands that our members rely on their input as they manage patients' care.

Emerging Trend in Use of Unqualified Rehabilitation Physicians and Directors of Rehabilitation

AAPM&R is concerned that existing CMS standards for important physician leadership positions in IRFs do not provide sufficient clarity to ensure that IRF patients receive optimized rehabilitation care, and as a result, IRFs are increasingly hiring or contracting with unqualified or underqualified specialists to serve in the role of rehabilitation physician. For example, we are aware of at least one large, for-profit IRF chain where approximately 30 percent of its rehabilitation physicians are not physiatrists. We find this problematic when one of the leading rehabilitation industry groups suggests that rehabilitation teams should be led by physiatrists, as noted above. We are also aware of a large, for-profit IRF chain that has an established policy specifying that the “specialized training and experience” requirement can be

neuropsychologists, cognitive therapists, social workers/case managers and dietitians, as well as prosthetists, orthotists, recreation therapists and other clinicians.” Downloaded from <https://amrpa.org/For-Patients/Inpatient-Hospital-Level-Medical-Rehabilitation-Improves-Lives> on June 14, 2019.

met by a mere 20 hours of continuing medical education credits focused on inpatient rehabilitation – a standard that we believe is distressingly inadequate, and one that does not even comport with existing requirements that require **both** specialized training **and** experience, not just one or the other.

To raise our concerns about this alarming trend, AAPM&R included comments in response to the Solicitation of Comments Regarding Changes to the Use of Non-Physician Practitioners in Meeting the Requirements Under § 412.622(a)(3), (4), and (5) in the IRF setting, which was included in the FY 2019 IRF proposed rule. We also brought a contingent to meet with CMS staff in the Division of Institutional Post Acute Care earlier this year. Through these avenues, we articulated why physiatrists should serve as the gold standard when defining the director of rehabilitation and rehabilitation physician positions in inpatient rehabilitation settings, consistent with an AAPM&R position statement released in January. While we recognized that the likelihood of CMS' immediate adoption of our position statement was low without further study, we believed that it was important for us to speak on behalf of our membership in the goal of protecting the integrity of the inpatient medical rehabilitation field. Equally importantly, *we believed that AAPM&R's position would generate discussion and prompt CMS to engage with AAPM&R and other appropriate stakeholders to address questions about necessary qualifications for IRF physicians*, and we left the meeting with CMS staff optimistic that CMS would continue to examine this issue in partnership with AAPM&R.

To our surprise, rather than engage with a key stakeholder constituency on this critical matter where there is clear dispute, CMS instead released its proposal to weaken the definition of rehabilitation physician only a month after our meeting. *We believe CMS' proposed approach is premature given the disagreement in the field.* Additionally, we believe the Administration should be taking steps to strengthen standards for high quality care, rather than erode them by diluting rehabilitation physician qualifications. We believe that a better approach would be to delay any changes to current regulations while stakeholders work to develop a consensus approach.

Unintended Consequences of CMS' Proposal

Should CMS finalize its proposal to weaken the definition of rehabilitation physician as proposed, AAPM&R is concerned that the trend of IRFs engaging the services of unqualified physicians to serve as rehabilitation physicians would accelerate. Under the proposal, CMS would explicitly update regulation text to defer to IRFs to determine who is qualified to act as a rehabilitation physician. This change would virtually eliminate CMS' oversight

responsibility with respect to ensuring that IRFs engage the services of qualified physicians. By including this language in regulation text, if there were an instance when an IRF clearly relied on the services of an unqualified physician to provide rehabilitation physician services, CMS would have little basis for holding the IRF accountable, since the regulation would leave the determination fully to the discretion of the IRF.

AAPM&R believes that this change would give IRFs free rein to establish their own definitions for what qualifies as “specialized training and experience in patient rehabilitation” – regardless of whether or not informed stakeholders, including Medicare contractors, would agree. As more physicians without necessary qualifications take on the role of rehabilitation physician, AAPM&R is concerned that CMS’ proposal would result in serious unintended consequences, as detailed below.

Potential Reductions in Quality of Care for IRF Patients

As IRFs increasingly rely on unqualified physicians to serve as rehabilitation physicians under CMS’ proposal, AAPM&R believes that there will be a greater risk that quality of care for IRF patients will be reduced. Furthermore, since the proposal would essentially allow IRFs to set their own standards for rehabilitation physician qualifications, AAPM&R is concerned that patients seeking IRF care may experience vastly different quality of care, which may vary based on factors such as geographic location or IRF ownership.

Physicians with insufficient training and experience may have a poor understanding of rehabilitation, with limited ability to engage in informed and thorough patient evaluation, to make patient- and condition-specific prognoses, or to develop appropriately-tailored plans of care. They may also have insufficient understanding of common rehabilitation techniques and lack experience in managing a multi-disciplinary rehabilitation care team.

These limitations may lead to poor or non-optimized outcomes for patients in IRFs. For example, patients may experience slow progress in attaining improvements in clinical status since physicians without expertise may not be aware of all treatment options or how to develop a comprehensive plan of care that leverages resources most effectively. Unqualified physicians may also mismanage co-occurring conditions such as spasticity, dysphagia, or neurogenic bladder or bowel conditions, or miss underlying diagnoses such as neuropathy and Parkinson’s disease. Patients may also receive inappropriate or poorly fitted devices (e.g. wheelchairs, prostheses, and orthoses).

This is a concern for many of our members, who have been alarmed to hear of CMS' proposal. In fact, when we informed our members of this proposal, over 1,000 members and counting were motivated to submit comments to CMS. Many have even raised concerns that this policy would be discriminatory against patients with disabilities who seek IRF care after illness or injury, and who are among the most marginalized and at-risk patient populations in the country.

Unfortunately, the quality measures that are included under the IRF Quality Reporting Program (QRP) do not adequately assess IRFs on all of these outcomes or provide clear visibility into the treatment IRF patients receive. And while the IRF QRP does include measures related to function and mobility, which reflect key goals for rehabilitation, questions regarding the reliability of functional assessment data have arisen, as highlighted in the Medicare Payment Advisory Commission's (MedPAC's) March 2019 Report to Congress.² In the report, MedPAC notes that its analysis of IRF assessment data suggests that IRFs differ in their assessment of patients' motor and cognitive function. For example, MedPAC found that patients in high-margin IRFs were less severely ill and resource intensive during preceding acute care hospitalizations than those in low-margin IRFs, but once patients were admitted to and assessed by the IRF, the average patient profile changed, with patients treated in high-margin IRFs appearing to be more disabled than those in low-margin IRFs. MedPAC noted that this pattern persisted across case types, and that it suggests that assessment and scoring practices contribute to greater profitability in some IRFs. ***Given this lack of targeted quality measures and variability in functional assessment results, AAPM&R is concerned that financial incentives, rather than quality incentives, drive some IRFs' hiring and contracting decisions, and that their disregard for meaningful training and experience among their rehabilitation physicians will only increase if CMS finalizes its policy to weaken the definition of rehabilitation physician as proposed.***

Increased Likelihood of Improper or Inefficient Healthcare Utilization

Physicians without specialized training and experience in inpatient rehabilitation may also engage in practices that increase the improper and

² Medicare Payment Advisory Commission. 2019. *March 2019 Report to the Congress: Medicare Payment Policy*. Chapter 10. Available at http://www.medpac.gov/docs/default-source/reports/mar19_medpac_ch10_sec.pdf?sfvrsn=0

inefficient utilization of limited healthcare resources. For example, unqualified physicians may inappropriately concur with admission recommendations for patients with insufficient acuity or likelihood of benefitting from inpatient rehabilitation care. Our members have reported that at least one for-profit IRF is pressuring its rehabilitation physicians to approve such inappropriate admissions, despite their best judgement based on their extensive PM&R training. This has even led some of our members to quit their jobs or terminate their relationships with these IRFs. We are concerned that physicians without such specialized training and experience would not have the knowledge or judgement to recognize when such admissions would be improper.

Unqualified physicians may also develop plans of care that are ineffective or non-optimized, potentially leading to prolonged delivery of high-cost services, complications of mismanaged co-occurring conditions, and inappropriate use of equipment and supplies. Such outcomes would not only harm patients and potentially increase their cost-sharing requirements, but they would also contribute to improper payments and excessive spending by the Medicare program.

Reduction of Program Integrity Oversight

This policy, if finalized, would undermine CMS' ability to engage in appropriate program integrity oversight. Our understanding is that this policy primarily serves to reduce the burden associated with audits, since on a day-to-day basis CMS adopts a general deference to IRF determinations regarding rehabilitation physician qualifications – even absent the change in policy as proposed. Some IRFs may be concerned that auditors could question the qualifications of some rehabilitation physicians who do not demonstrate sufficiently robust training and experience in inpatient rehabilitation care, which could impact IRF payment for patients whose care is managed by such physicians. If CMS regulations explicitly defer to the IRF's judgement on the rehabilitation physician's qualifications, then CMS would have little basis to hold IRFs accountable upon audit for this requirement.

We do not believe it is in the interest of the Medicare program for CMS to relinquish this oversight responsibility. While we recognize that the majority of IRFs will likely adhere to the spirit of the requirements for specialized training and rehabilitation, we are concerned that there will always be bad actors that will seek to take advantage of flexibilities that exist, or even violate existing requirements – as in fact is already happening.

We also appreciate that CMS may expect to rely on other regulations regarding IRF coverage criteria, documentation, and minimum requirements for care delivery and oversight to protect against the major program integrity vulnerabilities regarding IRF care (e.g. medical necessity determinations or poor care delivery). We disagree that such an approach is sufficient, as violations of such requirements would only be identified in limited cases upon audit, while the risk of violations, sub-standard care, and poor outcomes would rise program wide. Further, given limitations of existing quality measures noted above, we question whether the impacts on patient care would even be detected.

Ultimately, AAPM&R believes that the value that patients and the Medicare program derive from the IRF benefit is driven by the specialized inpatient rehabilitation expertise provided by qualified rehabilitation physicians. It will be critical for CMS to retain authority to ensure that IRFs are offering this expertise in order to maintain the value of IRF care that is so critical for a small but complex and high-cost proportion of the Medicare population.

Devaluation of Physiatry Training

AAPM&R also opposes CMS' proposal to weaken the definition of rehabilitation physician because it devalues the expertise that is obtained through years of education and training required to become board certified or board eligible in PM&R. Despite the value that our specialization provides, CMS' proposal would effectively equate it to 20 hours of continuing medical education credits obtained during a single weekend course – and CMS' proposal is opening the door for even lower qualifications. AAPM&R is concerned that CMS' proposal would therefore discourage future physicians interested in PM&R from pursuing this deeper knowledge and expertise in inpatient rehabilitation care, ultimately reducing access to this specialized care for the IRF-eligible patients who require it.

Lack of Clear Rationale

AAPM&R is confounded by CMS' decision to propose this targeted change regarding one isolated area of IRF policy, for which there is clear disagreement. While AAPM&R appreciates that CMS has emphasized burden reduction under its Patients Over Paperwork initiative, we believe that the impact of this proposal on burden reduction is limited and that the potential risk to the quality and efficiency of IRF care more than offsets any benefit that may accrue. AAPM&R also notes that there are numerous other steps that CMS could take to reduce burden not only for rehabilitation facilities, but also for the physicians and other practitioners who practice in those facilities. These

recommendations have previously been submitted by AAPM&R to CMS in-person and in writing multiple times over the last year.³ Additionally, AAPM&R has partnered with IRF stakeholders, including AMRPA and the Federation of American Hospitals, to develop and submit joint recommendations for burden reduction to CMS for which there is largely consensus. If CMS were truly motivated to reduce burden, it is not clear why CMS would not start with those consensus opportunities.

CMS notes that this change to the definition of rehabilitation physician is necessary to “ensure that IRF providers and Medicare contractors have a shared understanding” of regulatory requirements. This language suggests that Medicare contractors are making determinations that some rehabilitation physicians do not meet the standard of having specialized training and experience in inpatient rehabilitation – despite IRF determinations that the required qualifications have been met. If that is the case, it appears that CMS is proposing to intentionally weaken the standards such that enforceable qualifications would no longer apply, further raising program integrity concerns about whether the IRFs in question are truly providing IRF-level care. AAPM&R finds this notion alarming. Likewise, in 2010, CMS stated the following in a document entitled, “Follow-Up Information Regarding the Inpatient Rehabilitation Facility (IRF) Coverage Provisions in the Fiscal Year 2010 Final Rule”:

“Definition of a ‘rehabilitation physician’: For the moment, we do not believe that we need to go further in defining a rehabilitation physician other than to say that he or she must have specialized training and experience in rehabilitation. The responsibility is on the IRF to ensure that the rehabilitation physician(s) who are making the admission decisions and treating the patients have the necessary training and experience. If we later find that this is becoming a problem and we need to further define the qualifications, we will consider revising our policy accordingly.”

AAPM&R fails to understand how the current definition has become a problem for which a weakening of the qualifications is required. To the contrary, AAPM&R believes that the opposite is true, and that the definition should be strengthened to protect against the erosion in qualifications that have already emerged.

³ AAPM&R intends to submit comments to the CMS RFI; Reducing Administrative Burden to put Patients over Paperwork.

AAPM&R also notes that there are numerous examples throughout Medicare regulations where CMS establishes standards for clinician skills, training, and expertise to serve in certain roles or perform certain functions. In some cases, CMS also articulates specific years of training or specific types of specialties or certifications that must be met. It is not clear why CMS believes it is appropriate to revise regulation text explicitly for rehabilitation physicians to defer to IRF determinations, as opposed to the numerous other instances where CMS could equally weaken standards by updating regulation text to explicitly defer to the regulated entities.

Stakeholder Engagement

AAPM&R has been reaching out to other patient, clinician, and IRF stakeholders to raise awareness about CMS' proposal to weaken the definition of rehabilitation physician, including the potential implications regarding the quality and efficiency of care provided to IRF patients. ***We have been pleased to learn that beneficiary advocacy organizations, professional societies, and several rehabilitation hospitals and health systems recognize the threat that CMS' proposal poses and share our concerns.***

From our engagement with these groups, it is apparent that stakeholders from these different constituencies have concerns that CMS' proposal could reduce the quality of care that patients in IRFs receive. These groups recognize the value and necessity of IRF care for the most complex rehabilitation patients and the central role that a qualified rehabilitation physician plays in overseeing and directing that care. Specialty societies and provider organizations also recognize that lower quality and higher costs could have ripple effects into their own payments, particularly as CMS increasingly holds providers accountable for costs over the course of entire episodes of care, including post-acute care. Examples already exist within the Bundled Payments for Care Improvement (BPCI) Advanced model, or with the use of episode-based cost measures under the Merit-based Incentive Payment System (MIPS).

It is also AAPM&R's understanding that there is a split among IRFs regarding support for this proposal. While many agree that the risks under this proposal outweigh the benefits, others appear to place greater value on IRF autonomy and the burden reduction that accompanies the lower audit risk.

Despite this disagreement, AAPM&R has reached out to key representatives of the IRF industry, as well as from other rehabilitation patient and clinician stakeholders, and confirmed that they are interested in coming together to discuss the important issues implicated by CMS' proposal with the intent of

returning to CMS with consensus guidelines to better define the qualifications of a rehabilitation physician. *AAPM&R intends to lead this charge and believes that CMS should delay consideration of further changes to the existing regulations while we convene the necessary rehabilitation stakeholders and undertake this important work.*

Conclusion

AAPM&R believes that existing regulations maintain a standard for Rehabilitation Physician qualifications and ensure that CMS retains sufficient oversight authority over IRFs to protect patient care. This standard also provides sufficient confidence that the IRF is subject to an enforceable standard – not free to set its own standards. Furthermore, we believe that nothing under the existing regulations prevents IRFs from making good faith decisions regarding hiring and contracting determinations with licensed physicians who otherwise have specialized training and experience in inpatient rehabilitation.

Given these strengths of the existing regulations, and the numerous concerns detailed above, *AAPM&R urges CMS not to finalize its proposal to weaken the definition of rehabilitation physician at 42 CFR § 412.622 at this time. By not finalizing at this time, CMS provides rehabilitation stakeholders an opportunity to convene and develop a consensus list of qualifications of a rehabilitation physician to recommend to CMS.*

VIII. Proposed Revisions and Updates to the IRF Quality Reporting Program (QRP)

IRFs serve a valuable function in providing intensive, high-quality inpatient rehabilitation care to patients whose rehabilitation needs cannot effectively be addressed in other settings. Critical for achieving positive health outcomes – including but not limited to those captured under key measures within the IRF Quality Report Program – is a qualified rehabilitation physician, with specialized training and experience in inpatient rehabilitation.

AAPM&R urges CMS to recognize the value of specialized training and experience in rehabilitation care – as epitomized by the residency training received by physicians specializing in PM&R – in contributing to high quality IRF care, and to ensure that the linkage between such specialization and IRF-level care remain robust by not finalizing its proposal to weaken the definition of rehabilitation physician.

E. IRF QRP Quality Measures, Measure Concepts, and Standardized Patient Assessment Data Elements Under Consideration for Future Years: Request for Information

CMS indicates that it is considering measures related to opioid use and frequency for future consideration under the IRF QRP. While AAPM&R recognizes that the current opioid epidemic is one of the most devastating public health threats to our society, and we share the widespread concern regarding the risks that opioids pose to the individual patient and public when not used appropriately, *we have concerns with measures that focus solely on opioid use and frequency.* We recognize that chronic pain is the cause of suffering for more than 100 million Americans. As such, our specialty strives to mitigate overprescribing and to reduce stigma, while also having serious concerns about the risk of undertreatment of pain, particularly given that opioids are an important recourse for physiatrists treating acute and chronic pain when used appropriately for pain that cannot be resolved by other treatments alone.

AAPM&R believes that the type, dosage, and duration of opioid therapy is best determined by the treating physician's assessment of the individual patient needs, and that any quality measurement effort that applies an across-the-board approach that penalizes high dosage and/or frequent opioid usage without clearly accounting for patient needs would be problematic. For example, the Pain Management Best Practices Inter-Agency Task Force Draft Report on Pain Management Best Practices highlighted unintended consequences that arose as a result of misapplication of guidelines promulgated by the Centers for Disease Control and Prevention for prescribing opioids for chronic pain. *AAPM&R cautions CMS to take care when developing opioid-related quality measures to ensure that they do not result in similar unintended consequences that leave patients without access to critical treatments for pain management.*

CMS also indicates that it is considering standardized patient assessment data elements (SPADEs) focused on bowel and bladder continence including appliance use and episodes of incontinence. *AAPM&R supports collection of such data under the impairments SPADE category,* as specified in [AAPM&R's Recommendations on Post-Acute Care Data Standardization](#) (which are incorporated herein).

F. Proposed Standardized Patient Assessment Data Reporting Beginning with the FY 2022 IRF QRP

Standardizing patient assessment data among post-acute care (PAC) settings is important work that greatly affects AAPM&R's members. As noted in previous comments and in [AAPM&R's Recommendations on Post-Acute Care Data Standardization](#) (which are incorporated herein), AAPM&R recognizes that data standardization will help facilitate appropriate payment reforms and appropriate quality measures that reflect the setting in which rehabilitation care is being provided and continues to refer CMS to its posted recommendations. ***With respect to CMS' proposal to adopt a SPADE on pain interference, AAPM&R believes that this SPADE can provide useful information as it captures data on how pain affects function. However, we would urge caution with respect to how CMS intends to use this data, noting particular concern that collection of this data may inappropriately translate into an assessment of quality.*** AAPM&R believes that treatment decisions should be left to the clinical judgement of patients' treating physicians, working in collaboration with an interdisciplinary care team and consistent with the patient's goals of care, and we would have concerns with data collection that could create incentives that directly or indirectly interfere with those clinical decisions.

Additionally, with respect to new collection of SPADEs focused on social determinants of health (SDOHs), AAPM&R generally supports CMS' approach. However, AAPM&R recommends that CMS recognize disability status as a SDOH that contributes to overall patient access to care, health status, outcomes, and many other determinants of health. Statute requires CMS to assess appropriate adjustments to quality measures, resource measures, and other measures, and to assess and implement appropriate adjustments to payment based on those measures, after taking into account information related to social determinants of health. However, CMS' discussion of SDOHs does not detail how disability status may be factored into such adjustments to such measures or payments. The Assistant Secretary for Planning and Evaluation in its Report to Congress on Social Risk Factors and Medicare's Value-Based Purchasing Programs⁴ reported that disability is an independent predictor of poor mental and physical health outcomes, and that individuals with disabilities may receive lower-quality preventive care. Furthermore, disability is included

⁴ U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. 2016. Report to Congress: Social Risk Factors and Performance Under Medicare's Value-Based Payment Programs. Washington, DC.

in risk adjustment across many aspects of the Medicare program. AAPM&R recommends that, as CMS continues to collect and analyze data on SDOHs, CMS incorporate information about patients' disability status when considering adjustments to measures and payment across the Medicare program.

Additionally, AAPM&R recommends that CMS collect SPADEs regarding patients' independent living status, with or without long term services and supports, as well as their ability to return to work. For rehabilitation patients, these factors can contribute to quality of life, mental health outcomes, effectiveness of rehabilitation care, and more.

Other Comments

AAPM&R previously submitted letters, exchanged emails, and spoke with CMS staff on three other issues, as reiterated below: requesting clarification on residents' capabilities in IRFs; denials of IRF claims; and proposals to reduce physician burden in IRF settings.

Residents' Capabilities in IRFs

AAPM&R seeks clarification on the role of residents and their allowable responsibilities in IRFs. AAPM&R has previously submitted these questions and concerns to staff via a letter. Additionally, the list of questions below was submitted to the irfcoverage@cms.hhs.org email address. Specifically, we would appreciate clarification on the following questions:

Post-Admission Physician Evaluation

1. Can a resident conduct the post-admission physician evaluation (PAPE) if a supervising teaching physician is physically present during the entire evaluation?
2. Can a resident conduct the PAPE if a supervising teaching physician is physically present during only the critical or key portions of the evaluation? a. If yes, what elements does CMS specify are the critical or key portions of the evaluation?
3. Can a resident complete the documentation regarding the completion and findings of the PAPE if all three of the following criteria are met?
 - a. the teaching physician signs and dates the notes;

- b. the teaching physician documents agreement with the resident’s notes;
- c. and teaching physician’s documentation meets requirements specifying that the teaching physician was physically present during the critical or key portions of the service and detailing the extent of the teaching physician’s participation in the management of the patient (consistent with documentation requirements included in Section 100 of Chapter 12 of the Medicare Claims Processing Manual)?

Three Minimum Required Physician Face-to-Face Visits Per Week

1. Can a resident conduct the face-to-face visits if a supervising teaching physician is physically present during the entire evaluation?

2. Can a resident conduct the face-to-face visits if a supervising teaching physician is physically present during only the critical or key portions of the visit?
 - a. If yes, what elements does CMS specify are the critical or key portions of the visit?

3. Can a resident complete the documentation regarding the completion and findings of the visit if all three of the following criteria are met?
 - a. the teaching physician signs and dates the notes;
 - b. the teaching physician documents agreement with the resident’s notes;
 - c. and teaching physician’s documentation meets requirements specifying that the teaching physician was physically present during the critical or key portions of the service and detailing the extent of the teaching physician’s participation in the management of the patient (consistent with documentation requirements included in Section 100 of Chapter 12 of the Medicare Claims Processing Manual)?

We would note that AAPM&R members across the country have raised concerns that CMS guidance appears to place restrictions on residents’ ability to perform the above activities, which creates a disparity between activities that may be performed by residents in IRF settings versus other inpatient and outpatient settings. Furthermore, we are concerned that – if such activities may not be performed by residents – the IRF-specific restrictions limit the ability of rehabilitation residents to gain training and expertise in these critical elements of rehabilitation care.

Medicare Denials of Inpatient Rehabilitation Facility Claims

AAPM&R has concerns regarding denied IRF Medicare fee-for-service claims based on medical necessity and technical errors, as well as for denied prior authorization requests and claims submitted on behalf of Medicare Advantage beneficiaries.

AAPM&R routinely receives feedback from our members on the incidence and type of inpatient denials that our members regularly experience in their PAC practices, including incidence rates in IRFs. Based on our review, there are three general categories of denials that our members regularly experience: medical necessity denials; technical documentation denials; and Medicare Advantage denials.

I. Medical Necessity Denials

Over the years, CMS and, particularly, its contractors have offered inconsistent and conflicting interpretations and enforcement of medical necessity standards for IRF admissions, which has led to uncertainty in the field when making admission decisions. A prime example of this is the so-called “Goldilocks” rule for IRF coverage under which very few patients are deemed to be “just right” for IRF care.

Medicare audit contractors, particularly those involved in Comprehensive Error Rate Testing (CERT), appear to have imposed a “Goldilocks” coverage standard whereby the patient must be sick enough to require acute hospital care but not too sick to participate in intensive rehabilitation. The patient’s medical condition must meet an ill-defined “just right” standard that almost no patient seems to satisfy. CMS officials have, in fact, quoted this Goldilocks standard to IRF stakeholders during discussions involving IRF medical necessity reviews and error rates. This unpublished standard unduly limits physician judgment, deprives beneficiaries of necessary care, and is contrary to CMS regulations governing IRF coverage.

The Goldilocks rule appears to stem from a fundamental misunderstanding of the practice of rehabilitation medicine, which has led contractors to misapply the coverage regulation. A patient must be stable on admission—a patient cannot be so ill that he or she cannot participate in an intensive therapy program.⁵ CMS contractors err, therefore, when they mandate that the patient

⁵ 42 C.F.R. § 412.622(a)(3)(iii).

need the same level of medical management as in a general acute care hospital. The rehabilitation physician's role is not limited just to managing medical conditions and associated comorbidities. Rather, the rehabilitation physician is the leader of a multi-disciplinary team that focuses on restoring maximum function lost through injury, illness, or disabling conditions. The purpose of the IRF—and of the rehabilitation physician—is to improve the patient's ability to function while managing the overall medical condition of the patient. The rehabilitation physician manages the patients' conditions to enable the patient to participate in the intensive rehabilitation program safely and effectively. A patient may need IRF care even in the absence of comorbid medical conditions if the patient's functional deficits are severe or if participating in the therapy program places the patient at *risk* of developing comorbid conditions. From the perspective of our members, a physiatrist's role is to optimize functional outcome. The fact that physiatrists address all co-morbidities in addition to acute medical problems is one of the largest benefits of being admitted to an IRF.

Many audit contractors fail to understand the crucial role that rehabilitation physicians play in the IRF setting. Auditors treat IRFs as if they are general acute care hospitals and assume that IRF patients must meet the standard for acute care admission. These auditors erroneously believe that patients who are “not sick enough” cannot qualify for IRF care. Some auditors even deny coverage because patients *are stable* on admission—directly contrary to a regulation requiring the patient to be “sufficiently stable at the time of admission to be able to actively participate in the intensive rehabilitation therapy program.”⁶

The Goldilocks rule misses the critical point that IRFs are not acute care hospitals. Therefore, patients must be stable on admission. CMS and its contractors seem to default to the so-called Goldilocks rule, even though it is plainly contrary to Medicare regulations (42 C.F.R. § 412.622(a)(3)(ii) and (iii)). In doing so, CMS has undermined the objective standard that it intended to create in the 2010 IRF coverage and documentation regulation. CMS has created a subjective coverage standard that varies among the thousands of auditors that review IRF claims. As a result, Medicare beneficiaries and IRFs cannot accurately and consistently predict coverage.

⁶ *Id.*

IRF physicians must make their best medical judgment based on their medical training and professional expertise and hope a third-party, ex-post-facto, paper review determines that the patient was “just right” under the Goldilocks rule. If the physician’s judgment to admit a patient is undermined and second-guessed after the fact, the IRF is then denied all payment for care that was delivered in good faith and resulted in meaningful functional improvement for Medicare patients. The IRF then must navigate a Medicare appeals system that is woefully backlogged by many years. When Administrative Law Judge (ALJ) hearings are finally scheduled, rehabilitation physicians must divert their attention away from active patient care to reviewing patient files that are years old in order to convince an ALJ that the care rendered years before was reasonable and necessary.

We believe contractors auditing IRFs should be required to have on staff rehabilitation physicians with recent IRF experience to approve any IRF denial before a denial is issued. Additionally, IRFs and the physicians working in them should have the ability to communicate with the auditor during audits to ensure that the auditors and physicians understand each other’s methods and choices. Prior to denying a claim, an auditor should be required to bring any concerns to the IRF so that the treating physician can explain factors or reasoning that may not have been apparent from the medical record.

II. “Technical” Denials for Minor Documentation Deficiencies

The 2010 IRF regulations established some of the most onerous documentation requirements on IRFs of any of the post-acute care settings. CMS took this approach in order to standardize admission decisions and reduce the subjectivity of medical necessity reviews being conducted by CMS contractors based on the pre-2010 coverage requirements. The intent was to move toward satisfaction of more objective documentation requirements to demonstrate medical necessity. Most of these documentation requirements land squarely on the backs of the treating rehabilitation physician including the pre-admission screening, the post-admission physician evaluation, the plan of care and the recordation of the weekly team meetings. This regulatory burden likely

contributes to psychiatrists reporting among the highest rates of physicians who report “physician burn-out” across physician specialties.^{7, 8}

What was designed to be a more objective and accountable documentation system to demonstrate the medical necessity of IRF care has devolved into a frustrating and unsustainable documentation burden on rehabilitation physicians and other IRF professionals. CMS contractors routinely comb through patient files to identify minor documentation errors or omissions, faulty signatures and other minor deficiencies. These audits not only make physician jobs more difficult, but also provide little to no value for patients and their care. They also often lead to claims being routinely denied, either pre- or post-payment, and reimbursement for the entire IRF stay is either never rendered or recouped by the Medicare program. A more comprehensive list of reasons for technical denials follows, as reported by our membership:

- Pre-Admission Screening was not updated 48 hours prior to admission
- Pre-Admission Screening was not timely signed before patient arrived at the IRF (missed by 1 and 6 minutes respectively)
- Admission Order signatures missing, incorrect, or delayed
- Post-Admission Physician Evaluation was not completed within 24 hours after admission (missed by 1 hour)
- Team Conference notes do not make it clear that the meeting was run by the physician
- The minutes of therapy counted toward the three-hour rule have rounding errors

A wholesale denial of a three-week inpatient rehabilitation hospital stay based on minor documentation errors in a voluminous patient file is inequitable and inappropriate, especially after the patient was provided services and benefitted from the IRF plan of care.

AAPM&R seeks to work with CMS to limit this documentation burden, reduce the amount of unreasonable technical denials, and, simultaneously, maintain the integrity of the Medicare program by considering alternative options to denying an entire stay based on minor documentation errors.

⁷ Medscape National Physician Burnout and Depression Report 2018.
<https://www.medscape.com/slideshow/2018-lifestyle-burnout-depression-6009235#3>

⁸ Medscape National Physician Burnout, Depression & Suicide Report 2019.
https://www.medscape.com/slideshow/2019-lifestyle-burnout-depression-6011056?src=WNL_physrep_190116_burnout2019&uac=306605AJ&impID=1861588&faf=1

For your consideration, AAPM&R is resubmitting the following minor technical proposals to address documentation burden for physiatrists working in IRFs.

1. Eliminate “Technical” IRF Denials

An AAPM&R proposal since 2013

a. Proposal: Include an affirmative statement in the IRF regulation at 42 C.F.R. § 412.622 governing coverage and contractor audits that clarifies that isolated technical deficiencies in documentation shall not constitute the sole basis for denial of a claim.

b. Rationale: This proposal is consistent with verbal assurances made by CMS officials before the 2010 IRF regulations were implemented and would allow for a more standard review as conducted between Medicare contractors. It would also alleviate one of the most frustrating aspects for IRFs of providing services to Medicare beneficiaries and limit a large number of Medicare denials that are challenged by providers and wind up in the backlog at the Office of Medicare Hearings and Appeals (“OMHA”).

2. Permit Documentation Deadlines to Be Extended from 24-Hours to Midnight of the Next Calendar Day

An AAPM&R proposal since 2017

a. Proposal: Permit documentation that is required to be signed by a physician or other rehabilitation professional within a certain timeframe to be completed by the end of the next calendar day, rather than the exact 24 hours determined by the time stamp in the electronic medical record (“EMR”).

b. Rationale: IRFs are subject to several requirements that mandate completion of activities (e.g., the post-admission physician evaluation) within a 24-hour timeframe from admission. However, since the widespread adoption of EMRs, time stamps have made this requirement extremely burdensome on physicians and unnecessary for the safe medical management of IRF patients. This proposal would provide more reasonable documentation deadlines that would result in fewer denials for minor documentation errors. The proposal would also

improve the ability of physicians to direct their rehabilitation teams and provide greater flexibility of IRFs to assign staff to meet patient needs. We believe the intent of this regulation is to ensure timely visitation of the patient, which we would never want to obstruct. As such, we support the intent of the regulation, which was written before the proliferation of EMRs. We believe requiring a submission at some point during the next calendar day supports the intent of the regulation without holding physicians to meeting the deadline in 24-hours down to the very minute.

3. Permit Documentation Deadlines to Be Extended when Falling on a Weekend or Federal Holiday

An AAPM&R proposal since 2013

a. Proposal: Permit documentation that is required to be signed by a physician or other rehabilitation professional within a certain timeframe to be completed by noon of the next business day if the original deadline falls on a weekend or Federal holiday.

b. Rationale: This provides more reasonable documentation deadlines that would result in fewer denials for minor documentation errors. The proposal would improve the ability of physicians to direct their rehabilitation teams and provide greater flexibility of IRFs to assign staff to meet patient needs.

III. Managed Care Denials

Our members routinely report that Medicare is becoming a two-pronged program where fee-for-service beneficiaries have access to IRF care and Medicare Advantage (MA) enrollees do not. This is reflected in Medicare Payment Advisory Commission (MedPAC) data that demonstrates that MA enrollees are far less likely to be admitted to an IRF than fee-for-service Medicare beneficiaries (i.e., approximately one third the fee-for-service IRF admission rate).⁹ Decisions by MA plans not to admit certain patients for inpatient rehabilitation hospital services, despite referrals from physiatrists to such IRFs, can be appealed and often are.

⁹ Report of the Medicare Payment Advisory Commission, March 2018

However, by the time a decision is rendered, the patient has routinely been discharged from the acute care hospital and is sent to either a skilled nursing facility or to home health instead. This delay amounts to a denial of IRF care and creates a sentinel effect where referring acute care hospitals no longer even try to admit MA patients into IRFs, but instead, discharge patients directly to SNFs and home health, despite the needs of patients for inpatient, hospital-based, intensive and coordinated rehabilitation.

A similar phenomenon was recounted in a recent OIG study. On September 27, 2018, the U.S. Department of Health and Human Services Office of Inspector General (OIG) released a report regarding service and payment denials by Medicare Advantage Organizations (MAOs).¹⁰ The OIG reviewed data from 2014 to 2016, and its report contained the following key findings:

- When beneficiaries and providers appealed preauthorization and payment denials, MAOs overturned 75% of their own denials. Independent reviewers at higher levels of the appeals process overturned additional denials in favor of beneficiaries and providers. These claims involved both inpatient and outpatient claims across the MA program. These findings were not related solely to IRFs, but the conclusions in this report are applicable to IRFs nonetheless.
- This high number of overturned denials raises concerns that Medicare Advantage beneficiaries and providers are regularly improperly denied services and payment. These findings are especially concerning because beneficiaries and providers rarely use the appeals process, likely in part since it is so arduous.
- Audits by CMS have uncovered widespread and persistent MAO performance problems related to denials of care and payment. Because CMS continues to uncover the same types of violations each year, additional action is needed by CMS to address these issues.

The AAPM&R is very troubled that MA plans continue to deny medically necessary inpatient rehabilitation care at staggering rates and are circumventing the requirement that MA plans cover the same benefits that the fee-for-service program covers.

¹⁰ U.S. Dep't of Health & Human Servs., Office of Inspector General, OEI-09-16-00410, Medicare Advantage Appeal Outcomes and Audit Findings Raise Concerns About Service and Payment Denials (Sept. 2018).

MA enrollees seeking access to medically necessary post-acute care are often faced with significant and insurmountable administrative hurdles which cause delayed and denied access. Instead of following binding Medicare coverage criteria¹¹, MA plans frequently apply private, proprietary decision tools to make coverage decisions that override Medicare coverage policy, expert clinician decisions, and patients' wishes and preferences. These proprietary guidelines do not conform to Medicare coverage criteria, yet they are being used to deny patients access to medically necessary rehabilitation care. The effect of this practice is to divert many enrollees who qualify for inpatient rehabilitation to clinically inappropriate lower-acuity settings, such as nursing homes and home care, putting them at serious risk for adverse medical events, less successful rehabilitation outcomes, and significantly reduced longevity and quality of life.

Based on reports from our members, the rates of pre-authorization denials and retroactive claim denials have steadily risen as MA plans increasingly rely on these proprietary guidelines, defer to the plans' own medical or clinical staff who lack rehabilitation physician expertise, and erect other administrative barriers that compromise enrollees' access to IRF care.

We ask CMS to address the use of proprietary admission guidelines by MA plans and the enforcement of the Medicare Managed Care Manual which requires Medicare Advantage enrollees to receive the same benefits as the fee-for-service beneficiaries. We would also like CMS to address whether CMS can restrict MA plans from using prior authorization with respect to IRF admissions in order to achieve parity in rates of access to IRF care between MA and original Medicare enrollees.

For your consideration, AAPM&R is resubmitting the following proposals to address physician burden related to the prior authorization process for admitting patients to IRFs.

¹¹ The Medicare Managed Care Manual states that, "Several original Medicare covered benefits and services are covered only for specific benefit periods, e.g., inpatient hospital services, skilled nursing facility services, and inpatient psychiatric hospital services. While an MA plan may offer additional coverage as a supplemental benefit, it may not limit the original Medicare coverage. MA plans must provide their enrollees with all basic benefits covered under original Medicare. Consequently, plans may not impose limitations, waiting periods or exclusions from coverage due to pre-existing conditions that are not present in original Medicare." Medicare Managed Care Manual Chapter 4. Revision 121, Issued: 04-22-16.

1. Clarify that Medicare Advantage Plans Must Use the Same Coverage Criteria as Applicable to Traditional Medicare

New AAPM&R proposal for 2019

a. Proposal: Specify in the Medicare Advantage (“MA”) regulations and annual MA Call Letter that MA plans are bound to apply the same coverage criteria applicable to patients enrolled in traditional Medicare for purposes of admission to inpatient rehabilitation hospitals and units.

b. Rationale: This proposal addresses a serious problem that is materially restricting access to IRF care. Currently, MA plans are required to provide all Medicare covered services and comply with all Medicare coverage regulations and manuals. However, they often use more restrictive proprietary guidelines instead of Medicare Part A coverage criteria for IRFs. This is reflected in Medicare Payment Advisory Commission (“MedPAC”) data that demonstrate one third the amount of patient access to the IRF setting under the MA program than under traditional Medicare.

2. Require a Rehabilitation Physician for the “Peer-to-Peer” calls in the Prior Authorization Process in Medicare Advantage Plans

New AAPM&R proposal for 2019

a. Proposal: Require a rehabilitation physician to complete the “peer-to-peer” calls for prior authorization of MA beneficiary admission to an IRF.

b. Rationale: Requiring a rehabilitation physician to complete peer-to-peer calls for prior authorization of MA beneficiary admission to an IRF would allow for the two physicians to be true peers. Under current policies, a rehabilitation physician may be required to provide clinical justification for IRF services to a physician trained in another medical specialty who is not as accustomed to the work physiatrists do, the patients that physiatrists work with, and the factors in patient evaluation that physiatrists examine in making admission decisions.

Conclusion

Thank you for your consideration of these comments. If you have any questions or would like further information, please contact AAPM&R’s Director of

Advocacy and Government Affairs, Reva Singh, JD/MA, at rsingh@aapmr.org
or 847-737-6030.

Sincerely,

A handwritten signature in black ink, appearing to read "Peter C. Esselman". The signature is fluid and cursive, with the first name "Peter" being the most prominent.

Peter C. Esselman, M.D.
President