aapm&r

9700 W. Bryn Mawr Ave., Ste. 200
Rosemont, IL 60018
www.aapmr.org

PHONE 847.737.6000
FAX 847.754.4368
info@aapmr.org

August 31, 2026

Gift Tee
Director, Division of Practitioner Services
Hospital and Ambulatory Policy Group
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: <u>American Academy of Physical Medicine & Rehabilitation's Serious Concerns Regarding the 2027 IRF PPS Final Rule's Interdisciplinary Team Conference and Therapy Initiation Requirements</u>

Dear Director Tee:

On behalf of the American Academy of Physical Medicine & Rehabilitation ("AAPM&R") membership, we write to respectfully request a meeting with you and your colleagues at the Centers for Medicare and Medicaid Services (CMS) to discuss our significant concerns regarding the 2027 Inpatient Rehabilitation Facility Prospective Payment System ("IRF PPS") final rule's changes to the IRF coverage criteria requiring (1) a patient's first interdisciplinary team ("IDT") conference to take place within four days of admission and (2) all therapies to be initiated within 36 hours from midnight on the day of admission. AAPM&R understands that these significant changes are scheduled to take effect on October 1, 2026, one month from the date of this letter.

Given AAPM&R's serious concerns with these policies, as expressed in our prior comments on the proposed rule and outlined in detail in this letter, we strongly urge (CMS) to rescind these changes to the IRF coverage requirements. At a minimum, CMS should delay implementation to allow IRFs sufficient time to operationalize the new requirements and adequately prepare rehabilitation physicians and interdisciplinary teams. Implementing these changes on the current timeline would impose substantial additional administrative and scheduling burdens on rehabilitation physicians practicing in nearly 1,200 IRFs nationwide, without a demonstrated corresponding benefit to Medicare beneficiaries. Of particular concern, these requirements may divert rehabilitation physicians' limited time away from direct patient care, reducing their capacity to provide needed clinical services

aapm&r
9700 W. Bryn Mawr Ave., Ste. 200
Rosemont, IL 60018
www.aapmr.org
PHONE 847.737.6000
FAX 847.754.4368
info@aapmr.org

to Medicare beneficiaries in both inpatient and outpatient settings. We therefore urge CMS to carefully consider whether the additional regulatory burden imposed by these policies is justified by any meaningful improvement in the quality or coordination of rehabilitation care.

AAPM&R is the national medical specialty organization representing more than 10,000 physicians who are specialists in physical medicine and rehabilitation ("PM&R"). PM&R physicians, also known as physiatrists, are medical experts in treating a wide variety of conditions affecting 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, patient-centered treatment plans. Physiatrists utilize cutting edge as well as time-tested treatments to maximize function and quality of life. Due to their training and expertise, PM&R physicians are uniquely qualified to help guide the multidisciplinary planning effort needed to address the medical and rehabilitation needs of persons served in IRFs.

Four-Day IDT Conference Requirement

The regulatory provision at 42 C.F.R. § 412.622(a)(5) requires IDT team meetings to be held "at least once per week throughout the duration of the patient's stay." CMS proposed to revise 42 C.F.R. § 412.622(a)(5) to require that an interdisciplinary team meeting be held by the fourth day of admission. In the proposed rule, CMS considered the day of admission as "Day 0." Therefore, under the proposed policy, if a patient were to be admitted at 6:00 pm on a Thursday, the physician and the rehabilitation team would have to complete the initial IDT conference by Monday at 11:59 pm. However, in the final rule, CMS instead changed its policy to consider the day of admission as "Day 1." Under the finalized policy, therefore, if a patient is admitted on Thursday, December 24, 2026, the team must complete the initial IDT conference by Sunday at 11:59 pm. This requirement could necessitate holding a team conference on Christmas Day or during the immediately following weekend—a period when physicians and other rehabilitation team members traditionally rely heavily on cross-coverage. In many cases, those participating in the conference would not even be members of the patient's primary treatment team when regular staffing resumes on Monday. At the same time, covering clinicians, nurses, therapists, and case managers are often responsible for substantially larger patient workloads because of colleagues' holiday absences. Requiring these individuals to divert time from direct patient care to participate in additional,

aapm&r
9700 W. Bryn Mawr Ave., Ste. 200
Rosemont, IL 60018
www.aapmr.org
PHONE 847.737.6000
FAX 847.754.4368
info@aapmr.org

time-sensitive team conferences may therefore detract from, rather than enhance, the quality of care provided.

Suggesting that facilities simply schedule additional staff does not reflect the operational realities of inpatient rehabilitation. Holiday coverage schedules are typically established many months in advance to ensure adequate patient care while also allowing physicians, nurses, therapists, case managers, and other team members a reasonable opportunity to spend time with their families. A regulatory requirement that effectively compels facilities to restructure longstanding holiday staffing arrangements—without a demonstrated corresponding benefit to patient care—creates substantial burden while offering little apparent clinical value.

We also urge CMS to consider the unique challenges this requirement poses for rural IRFs, particularly smaller facilities that may be covered by a single rehabilitation physician. These physicians often rely on physicians from other specialties to provide medical coverage on weekends and holidays. While these covering physicians may be well qualified to address patients' general medical needs, they may not have the rehabilitation expertise or familiarity with the patient's rehabilitation course necessary to effectively lead an interdisciplinary team conference. Requiring a conference under these circumstances risks turning what should be a meaningful exercise in interdisciplinary rehabilitation care planning into a compliance exercise that adds burden without improving—and potentially detracting from—the quality of patient care.

AAPM&R is extremely concerned that the finalized IDT requirement does not align with the purpose of the IDT conference, fails to consider the interdisciplinary care provided to an IRF patient throughout their rehabilitation stay, and will be exceedingly difficult to operationalize in advance of the October 1 deadline identified by CMS. This is a major change in operations for all IRFs and is ill-advised for many reasons, even if insufficient notice were not an issue. Additionally, AAPM&R is concerned that the IDT policy finalized by the agency runs afoul of the Administrative Procedure Act's ("APA's") notice and comment requirements, in particular, the "logical outgrowth" doctrine, discussed more fully below.

The Finalized IDT Requirement Does Not Align with the Purpose of the IDT Conference

The purpose of the IDT conference is for the IDT "to implement appropriate treatment services; review the patient's progress toward stated rehabilitation

aapm&r
9700 W. Bryn Mawr Ave., Ste. 200
Rosemont, IL 60018
www.aapmr.org
PHONE 847.737.6000
FAX 847.754.4368
info@aapmr.org

goals; identify any problems that could impede progress towards those goals . . . reassess previously established goals in light of new impediments, revise the treatment plan in light of new goals, and monitor continued progress toward those goals."[1] ***Requiring an IDT conference to take place within four days of admission, or practically, within three days in some instances, hinders, rather than advances, these goals.***

Requiring a formal IDT meeting before sufficient clinical information has developed can produce one of two undesirable outcomes: the team either holds a meeting that is necessarily preliminary and then must revisit the same issues shortly thereafter; or clinicians feel compelled to make premature judgments simply because a regulatory deadline requires them to do so. Neither outcome advances the coordinated, patient-centered care that the IDT conference is intended to facilitate.

CMS should ensure that its regulatory requirements reinforce, rather than undermine, the purpose of the IDT process. A formal conference is only valuable when it brings information together at a clinically appropriate point in the patient's stay. Although AAPM&R prefers the current 7-day rule, even a revision to the final rule that states an interdisciplinary team meeting must be held by the fifth day of admission instead of the fourth day of admission would be more manageable operationally. This approach would better align the formal conference with the actual clinical workflow of inpatient rehabilitation and would allow the rehabilitation physician and other members of the IDT to use the conference to meaningfully review and refine the patient's established plan of care based on the clinical information gathered during the initial days of the IRF stay.

Interdisciplinary Care is Central Throughout IRF Care Delivery

CMS's justification for the four-day team conference requirement rests on the assumption that "under the current policy, it is possible for an IRF patient to receive up to 7 days of care in an IRF without their full care team coordinating their treatment or discussing progress."[2] CMS expresses concern that this delay could result in "suboptimal treatment or inadvertently worsening the patient's health outcomes."[3] These assumptions are

---

[1] 42 C.F.R. § 412.622(a)(5)(ii).
[2] Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2027 and Updates to the IRF Quality Reporting Program, 91 Fed. Reg. 17195, 17213 (April 6, 2026).
[3] *Id.* at 17214.

aapm&r
9700 W. Bryn Mawr Ave., Ste. 200
Rosemont, IL 60018
www.aapmr.org
PHONE 847.737.6000
FAX 847.754.4368
info@aapmr.org

unfounded and inconsistent with the way rehabilitation care is coordinated in IRFs. A formal IDT meeting is only one component of interdisciplinary care and should not become the sole measure by which CMS determines whether interdisciplinary care is occurring throughout the patient's stay.

Interdisciplinary rehabilitation care is not created by a meeting on a particular day. The IRF model depends on continuous, dynamic collaboration among the members of the rehabilitation team. Physiatrists do not coordinate a patient's care only during a scheduled IDT conference. Rather, physiatrists from the time of admission—or even before admission—continuously integrate information from previous or current therapy sessions, nursing observations, medical assessments, diagnostic testing, medication response, cognitive behavioral assessments, family communications, and the patient's functional status and performance. The ongoing communication frequently results in real-time modifications to treatments, precautions, medications, therapy intensity, goals, discharge planning, and other aspects of the patient's rehabilitation program.

The Four-Day Timeframe as Stated in the Final Rule is Impractical and Largely Unworkable Given Practice Realities

Unlike individual patient documentation, such as the IPOC, which can be completed around clinical responsibilities, a formal interdisciplinary team meeting requires physicians, therapists, nurses, and case managers or social workers to be available at the same time. Requiring the IDT conference to be held within four days of admission creates significant scheduling challenges for rehabilitation physicians who provide both inpatient and outpatient care.

For instance, consider a patient who is admitted on a Thursday afternoon. As previously stated, under the new requirement, the team must complete the initial IDT conference by Sunday at 11:59 pm. IRFs face practical challenges in convening a meaningful IDT conference over the weekend, especially over holiday weekends. Staffing levels and the availability of key members of the rehabilitation team are often more limited on weekends than during the regular workweek. In addition, many IRFs experience predictable surges in admissions immediately before holidays as acute care hospitals seek to transfer medically stable patients prior to extended weekends. Consequently, rehabilitation physicians often manage their highest census while simultaneously covering for colleagues who are away. These realities leave IRFs with two options: (1) conduct the IDT conference on Friday, undoubtedly before the IPOC is finalized, or (2) conduct the IDT conference

aapm&r
9700 W. Bryn Mawr Ave., Ste. 200
Rosemont, IL 60018
www.aapmr.org
PHONE 847.737.6000
FAX 847.754.4368
info@aapmr.org

over the weekend and face challenges in having the appropriate clinicians at the table to maximize the benefit of the IDT conference. Further, as it stands, "burnout" of rehabilitation physicians practicing in IRFs caused by administrative and regulatory burden is a major factor impacting access to this level of specialized rehabilitative care. The IDT interpretation in the final rule will divert physician time away from direct patient care and will exacerbate PM&R physician burnout without improving clinical decision-making or patient outcomes.

Because this policy creates substantial challenges related to the timing of team conferences and regulatory compliance, it may inadvertently reduce access to IRF care for Medicare beneficiaries on certain days of the week or around holidays. For example, if an IRF has a single available bed on Christmas Eve and two otherwise appropriate candidates for admission—one Medicare beneficiary and one patient whose payer does not impose the same team conference requirement—the policy may unintentionally create an incentive to admit the non-Medicare patient in order to avoid imposing an additional conference requirement on limited holiday staffing. We are deeply concerned that a policy intended to strengthen the quality of IRF care could instead influence admission decisions based on payer requirements rather than clinical need and ultimately disadvantage Medicare beneficiaries seeking timely access to medically necessary rehabilitation.

Ensuring Appropriate Compliance Requires Additional Time

Adding more frequent IDT conferences and ensuring the appropriate staff are available to participate will require IRF education and significant operational changes to clinical workflows and staffing schedules. IRFs will need to establish processes for identifying when each patient's initial meeting must occur, coordinating the schedules of the required interdisciplinary team members, ensuring that the appropriate clinicians have sufficient information to meaningfully participate, and documenting the meeting in accordance with the new requirements. IRFs will also need time to educate and train staff regarding the new timing requirement and its implications for Medicare coverage.

Importantly, as written, this policy would effectively require IRFs to schedule team conferences at least three times per week to ensure compliance, even if conferences could occasionally be cancelled when no patients were newly admitted during the relevant timeframe. This requirement has implications that extend beyond the IRF. Many rehabilitation physicians also maintain outpatient practices, providing

aapm&r
9700 W. Bryn Mawr Ave., Ste. 200
Rosemont, IL 60018
www.aapmr.org
PHONE 847.737.6000
FAX 847.754.4368
info@aapmr.org

longitudinal specialty care to individuals with disabilities. Requiring physicians to remain available for additional team conferences may force them to reduce outpatient clinic time, thereby limiting access to physiatric care for Medicare beneficiaries. This concern is particularly acute given that many physiatry clinics are already booked several months in advance. With implementation only one month away, accommodating additional team conferences may require cancellation or rescheduling of previously scheduled—and often medically necessary—patient visits. Thus, a policy intended to enhance coordination of inpatient rehabilitation care could inadvertently reduce access to essential rehabilitation physician services for patients in the outpatient setting.

Given the significant time that these adjustments will take, **we again urge CMS to rescind this new requirement or at a minimum to delay implementation.**

Logical Outgrowth Concerns with the Final Day-Counting Methodology

Separate and distinct from our substantive clinical concerns, AAPM&R believes CMS's decision to count the day of admission as Day 1 raises serious concerns under the APA.[4] Specifically, we are concerned that the IDT policy finalized by CMS is not a "logical outgrowth" of the policy contained in the proposed rule, and therefore, stakeholders did not have a meaningful opportunity to comment on the proposal.

Section 553 of the APA requires an agency to provide interested persons with notice of a proposed rule and a meaningful opportunity to submit relevant data, views, and arguments.[5] Finalized rules must be a "logical outgrowth" of the proposed rule, meaning that interested parties "should have anticipated" that the change was possible and therefore should have commented on it.[6] Conversely, a final rule fails the logical-outgrowth test when affected parties would have had to "divine the agency's unspoken thoughts" because the final rule was surprisingly distant from the proposal.[7]

---

[4] 5 U.S.C. § 553
[5] 5 U.S.C. § 553(b)-(c).
[6] *Cavad Communications Co. v. FCC*, 450 F.3d 528, 548 (D.C. Cir. 2006); *CSX Transportation, Inc. v. Surface Transportation Board*, 584 F.3d 1076, 1080-81 (D.C. Cir. 2009).
[7] *CSX Transportation*, 584 F.3d at 1080; *Clean Air Council v. Pruitt*, 862 F.3d 1, 10 (D.C. Cir. 2017) (per curiam).

aapm&r
9700 W. Bryn Mawr Ave., Ste. 200
Rosemont, IL 60018
www.aapmr.org
PHONE 847.737.6000
FAX 847.754.4368
info@aapmr.org

CMS did not merely clarify the proposed rule; the agency expressly declined to finalize the proposed day-counting methodology and adopted a materially different approach that accelerates the compliance deadline for many admissions (from four days to, effectively, three days for any admissions that occur late in the day of admission). The result of CMS's change in position is consequential. It changes the amount of time available to an IRF to assemble the full interdisciplinary team and conduct the required meeting and, for many admissions, effectively accelerates the compliance deadline by one day. Stakeholders were not sufficiently on notice that CMS was considering treating the day of admission as "Day 1" instead of "Day Zero."

Had CMS proposed counting the admission date as Day 1, AAPM&R and other stakeholders would have had a meaningful opportunity to address the specific consequences of that approach. Stakeholders could have provided CMS with detailed information concerning late-day admissions; Thursday and Friday admissions; the availability of rehabilitation therapists and other IDT members; the limited clinical information that may be available during the earliest days of an IRF stay; and the resulting diversion of rehabilitation physicians from direct patient care. These are precisely the types of practical and clinical considerations that could have *and should have* informed CMS's decision regarding the appropriate timing for the IDT requirement.

AAPM&R therefore believes CMS should not treat the Day 1 counting methodology as a mere technical clarification. **We urge CMS to withdraw the finalized Day 1 counting methodology and return to the 7-day requirement.** At a minimum, CMS should delay implementation of the Day 1 methodology and provide affected stakeholders including AAPM&R with an opportunity to meet with Agency officials and to formally comment before enforcing a materially different compliance deadline.

Therapy Initiation Requirement

42 C.F.R. § 412.622(a)(3)(ii) provides that for an IRF claim to be considered reasonable and necessary, an IRF patient must "reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program," including at least three hours of therapy per day, at least five days per week. The current regulation states that, "The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF."[8] In the proposed rule, CMS proposed to clarify that

[8] 42 C.F.R. § 412.622(a)(3)(ii).

aapm&r
9700 W. Bryn Mawr Ave., Ste. 200
Rosemont, IL 60018
www.aapmr.org
PHONE 847.737.6000
FAX 847.754.4368
info@aapmr.org

all therapies—not just a minimum of one of the therapies that meet the requirements of the so-called "three-hour rule"—must be initiated within the 36-hour requirement.

In comments on the proposed rule, stakeholders, including AAPM&R, expressed serious concerns with this policy. In particular, the policy could compromise rehabilitation physician decision-making. Rehabilitation physician orders, not preadmission screening ("PAS") documents, are the best source of evidence to determine which therapies are required to be provided within 36 hours of admission for a given patient. In the final rule, CMS attempted to address these concerns by clarifying that the requirement applies to "therapies and/or therapy evaluations that are ordered at admission, which may occur by a rehabilitation physician concurring with the PAS or ordering additional therapies at admission."[9]

We have strong concerns that the policy as finalized will be interpreted in a manner that circumvents the decision-making of the rehabilitation physician and adds new undue burdens on IRFs.

We also urge CMS to provide appropriate flexibility when a patient's clinical or functional status upon admission differs materially from what was anticipated based on documentation from the referring facility, or when an unexpected change in medical status occurs. Similar flexibility should be considered for patients who require hemodialysis on the day following admission, as dialysis may significantly limit their availability to participate in the evaluations, particularly as many persons with ESRD do not have the endurance necessary to complete back-to-back evaluations.

The Therapy Initiation Requirement Circumvents Rehabilitation Physician Decision-Making

CMS's policy does not address the common situation in which a therapy initially identified as relevant for the patient in the PAS documentation is later determined to be either unnecessary by the patient's rehabilitation physician or, more likely, not medically necessary until the patient progresses through the rehabilitation stay. In this scenario, the treating rehabilitation physician's clinical judgement after evaluating the patient should clearly take precedence over PAS documents. The PAS is

[9] Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2027 and Updates to the IRF Quality Reporting Program, 91 Fed. Reg. 48982, 49007 (Aug. 3. 2026).

aapm&r
9700 W. Bryn Mawr Ave., Ste. 200
Rosemont, IL 60018
www.aapmr.org
PHONE 847.737.6000
FAX 847.754.4368
info@aapmr.org

necessarily based on information available before admission, while the rehabilitation physician has the benefit of a direct evaluation of the patient and potentially more current information regarding the patient's medical condition, functional status, and rehabilitation needs.

We are particularly concerned that Medicare Administrative Contractors ("MACs") will read in new requirements to the regulatory text and require rehabilitation physicians to affirmatively state that they disagree with a therapy recommended in the PAS when they choose not to order it.

We urge CMS to expressly clarify that the 36-hour requirement applies to the therapy services prescribed in the physician's order, not the therapies that are listed in the PAS documentation. We also urge CMS to clarify that the regulatory requirements do not require a rehabilitation physician to document a separate statement of disagreement with the PAS when the physician, based on an evaluation of the patient, determines that a therapy identified in the PAS is not medically necessary or appropriate within 36 hours of admission. To the extent CMS believes that documentation of a change in the therapy plan is necessary, CMS should make clear that routine documentation of the physician's admission assessment and treatment orders may satisfy that requirement. Such clarification would prevent MACs from imposing additional documentation requirements that are not contained in the regulation and would appropriately preserve the rehabilitation physician's clinical judgment.

****

Given our substantial concerns with the finalized IDT conference and initiation of therapy requirements, we strongly urge CMS to rescind these policies or suspend implementation. Alternatively, we request that CMS work with stakeholders, including AAPM&R, to identify an implementation timeline that gives CMS appropriate time to provide additional guidance to stakeholders and gives rehabilitation physicians and IRFs appropriate time to operationalize these changes. Additionally, to decrease the risk of an unnecessary and unfair audit, we request that CMS not impose any enforcement for at least a year if the policy is implemented.

AAPM&R thanks CMS for consideration of our recommendations. We again request to meet with you on this issue and would welcome an opportunity to work collaboratively toward an approach that strengthens our

aapm&r
9700 W. Bryn Mawr Ave., Ste. 200
Rosemont, IL 60018
www.aapmr.org
PHONE 847.737.6000
FAX 847.754.4368
info@aapmr.org

mutual goals of quality interdisciplinary rehabilitation care. Should you have any questions about these comments or if you would like more information, please contact Melanie Dolak, MHA, Associate Executive Director, Health Policy, Practice, Quality and Research at mdolak@aapmr.org.

Sincerely,

Susan L. Hubbell, MD, MS, FAAPMR
Chair, Health Policy, Practice and Advocacy Committee

cc:

Kimberly Schwartz, MS, RN
Director of the Division of Institutional Post-Acute Care
Chronic Care Policy Group
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

IRFcoverage@cms.hhs.gov