AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

October 8, 2021

The Honorable Chiquita Brooks-LaSure
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-10765
P.O. Box 8016
Baltimore, MD 21244-8016

Delivered Electronically

RE: Agency Information Collection Activities; Proposed Collection; Comment Request; CMS - 10765 (Sept. 8, 2021)

Dear Administrator Brooks-LaSure:

As the only national trade association that advocates solely for the interests of inpatient rehabilitation hospitals and units, the American Medical Rehabilitation Providers Association (AMRPA) writes to express our profound concern about the second Information Collection Request (ICR) proposing an Inpatient Rehabilitation Facility (IRF) Review Choice Demonstration (RCD).[1] We again urge you in the strongest possible terms to withdraw this demonstration project and instead meet with IRF stakeholders to discuss ways to collaboratively achieve CMS' program integrity goals without undermining the IRF provider system and compromising patient care.

In the ten months since the Centers for Medicare and Medicaid Services (CMS) first proposed the IRF RCD (in a notice that was nearly identical to the second notice published in September 2021)[2], AMRPA has engaged extensively with our member hospitals of varying size, ownership status, and geographical location to assess the anticipated impacts of this proposed program. Across the board, we have heard emphatic concern about how this demonstration will essentially substitute inadequately qualified contractor discretion for physician judgment on medical necessity, resulting in (at best) significant resources being diverted to administrative red tape, and at worst, an unauthorized restriction of a vital benefit that serves some of the most medically complex patients in the Medicare program.

Under the proposed IRF RCD, contractors would perform a pre-claim or post-payment review on all Medicare fee for service (FFS) claims in certain states (starting first with Alabama and expanding subsequently to California, Pennsylvania and Texas, before being implemented in numerous other states over the five-year period). Once the demonstration commences, IRFs would remain subject to the demonstration until they receive a compliance rate of at least 90% and would then move to a more limited review process. Contractors performing reviews could include nurses, therapists, and physicians, and CMS does not currently include specialty or experience-related requirements – in stark contrast to the

[1] *Agency Information Collection Activities: Submission for OMB Review; Comment Request*, 86 Fed. Reg. 50,360 (Sept. 8, 2021).
[2] *See Agency Information Collection Activities: Proposed Collection; Comment Request*, 85 Fed. Reg. 81,208 (Dec. 15, 2020).

Anthony Cuzzola · Chair, AMRPA Board of Directors
Vice President/Administrator, Hackensack Meridian Health JFK Johnson Rehabilitation Institute
529 14th Street NW, Suite 1280, Washington, DC 20045 · Phone: 202-591-2469 · Fax: 202-591-2445

expertise CMS requires of IRF providers.[3] The geographic and demographic diversity of the states in the IRF RCD means that CMS would put all Medicare beneficiaries nationwide at risk of losing access to the services provided by IRFs.

For all of the reasons that AMRPA has conveyed to CMS through multiple discussions and through our extensive submission to the first Review Choice Demonstration notice (attached as Appendix I), the Association continues to fully oppose the demonstration. The demonstration will ultimately force IRFs to turn away patients for whom they would likely experience disagreements with contractors (based on AMRPA members' past experiences), particularly given the fact that the massive scope of the demonstration will limit the extent hospitals can endure the time- and labor-intensive appeals process. Furthermore, smaller hospitals and units (often with negative Medicare margins) could be forced to close due to the significant administrative resources and staff time required to handle the demonstration's reporting, which is precisely what occurred in select states during CMS' Recovery Audit Contractor (RAC) pilot program after its 2005 launch.

We understand that CMS views the purported success of demonstrations in other industries (e.g., home health) as justification for the proposed IRF RCD. In fact, CMS has often cited these demonstrations as a counter to our concerns about care delays and access issues. We once again urge CMS, however, to consider the marked differences between a demonstration focused primarily on documentation and one that involves a hospital-level admission (even more, an admission for which the timeliness of the intensive rehabilitation services is tied directly to patient outcomes).[4] In addition, by CMS' own admission, past program integrity demonstrations have inevitably encountered contractor operational issues that required CMS intervention, particularly in the beginning stages of the demonstration. The potential patient harm is exponentially magnified when applied to hospitalized patients in need of timely intensive medical rehabilitation.

We also believe provider concerns about reviewer qualifications are significantly different in the context of a home health claim compared to an IRF admission. This is evidenced by the fact that rehabilitation physicians actually turn away a high percentage of referrals, which is due to the rigorous IRF admission requirements, the highly specialized nature of inpatient rehabilitation, and the complex clinical profile of patients treated in our hospitals. We remain highly concerned that CMS has not anticipated the issues that will inevitably arise if this demonstration is simply repurposed for IRFs. In fact, guidance documents accompanying the second RCD notice inadvertently reference "episodes," which are a home health—not an IRF—concept. This clearly suggests that CMS is "cutting and pasting" the home health RCD (which focused on documentation) and applying it to IRFs where it will target medical necessity, a far more complex undertaking. We believe it would be far more prudent for CMS to work with stakeholders, such as AMRPA, and identify program integrity measures that are more appropriate for our field and do not pose the same risk to patient care.

Finally, we believe this extreme approach of *identifying* improper payments is well beyond CMS' demonstration authority. The very statute cited by CMS as the basis for the demonstration expressly authorizes the Secretary of Health and Human Services to use demonstration projects for "improved

[3] CMS requires that rehabilitation physicians be licensed physicians with specialized training and experience in rehabilitation, and further provides that it is the IRFs' responsibility to ensure that the rehabilitation physicians that are making the admission decisions and caring for patients are appropriately trained and qualified.

[4] AHA/ASA, GUIDELINES FOR ADULT STROKE REHABILITATION AND RECOVERY: A GUIDELINE FOR HEALTHCARE PROFESSIONALS FROM THE AMERICAN HEART ASSOCIATION/AMERICAN STROKE ASSOCIATION (2016), available at http://stroke.ahajournals.org/.

methods for the *investigation and prosecution of fraud* in the provision of care or services" covered by Medicare and Medicaid.[5] Despite this specific statutory charge, CMS asserts that the IRF RCD would "improve methods for *the identification*, investigation, and prosecution of *potential* Medicare fraud."[6] The applicable statute explicitly requires fraud to be the target - not simply payment errors or problems with medical record documentation. CMS can only develop or demonstrate methods for the investigation and prosecution of fraud that *CMS identifies through other means*, which it has failed to do so in the context of the proposed IRF RCD. As we emphasize in our recommendations below, we believe that the extreme step of subjecting any hospital to 100% review of their Part A claims must only follow an objective and verifiable finding of suspected fraudulent activity – a view that is clearly consistent with the relevant statutory language.

These are just a few of our most compelling concerns with the demonstration at this stage. To be clear, AMRPA believes the only sound policy determination related to the proposed RCD would be for CMS to fully withdraw the proposal. However, in the event CMS proceeds with the demonstration in some form, AMRPA offers the following recommendations aimed at improving contractor training, oversight and program transparency. While the Association was greatly disappointed to see that CMS made minimal changes to the proposed RCD following our first comment submission, we appreciated CMS' recent assertions that it would meaningfully consider AMRPA's recommendations at this stage and look to "make important tweaks to the program as a result of" this input. In that spirit, we provide the following recommendations for CMS' consideration, which we view primarily as critical patient safeguards:

- **The Demonstration Must be Delayed until After the PHE Ends:** As CMS is well-aware, IRFs continue to encounter challenges ranging from Public Health Emergency (PHE)-related staffing shortages to providing ongoing support to acute care hospitals facing new COVID-19 surges. In addition to these types of capacity-related burdens, the PHE also creates serious challenges for the contractors charged with reviewing claims given the numerous and significant IRF-specific waivers currently in place – which remain a necessity as IRFs respond to the ongoing PHE. Delaying the demonstration for at least 1-2 years after the PHE is declared over is a critical but commonsense step to ensure that both IRFs and reviewers have the time and resources necessary to comply with such an intensive review.
- **The Demonstration Must be Significantly Rescaled:** In numerous other CMS programs – such as its Targeted Probe & Educate (TPE) or Comprehensive Error Rate Testing (CERT) – CMS is able to assess compliance rates through a small sample of records. AMRPA therefore sees no reason why CMS cannot take the same approach in this demonstration, as this would significantly reduce the burdens facing hospitals and contractors alike. Given the catastrophic impact on patient access, CMS must *only* take the extreme step of performing 100% review of fee-for-service admissions after showing objective, measurable, and verifiable evidence of fraudulent activity by specific IRF(s).
- **Greater Transparency and Accountability is Required with Respect to Contractor Training and Oversight:** To date, CMS has provided limited detail as to how it will approach contractor training and education. AMRPA believes stakeholders must be part of these activities, and that CMS must also allow for continuous feedback from rehabilitation physicians on contractor performance. Furthermore, AMRPA specifically recommends that CMS employ a medical

[5] 42 U.S.C. § 1395b-1(a)(1)(J) (emphasis added).
[6] *Agency Information Collection Activities: Submission for OMB Review; Comment Request*, 86 Fed. Reg. 50,360 (Sept. 8, 2021).

rehabilitation review board to oversee contractor determinations, and that such a board issue public reports related to contractor performance.

- **Commonsense Refinements are Needed with Respect to Reviewer Qualifications, Review Timeframes & Other Key Program Features:** AMRPA reiterates the numerous operationally-focused recommendations from our first comment letter and urges CMS to meaningfully incorporate these improvements into the demonstration if/as it proceeds. For example, we believe that it is vital that CMS only utilize physicians who meet CMS' definition of a rehabilitation physician to review decisions regarding medical necessity. Absent this, CMS cannot have any reasonable expectation that its contractors are reaching appropriate determinations on these claims. Our other suggested refinements are included in the body of our previous letter (found in Appendix I).
- **Evaluation on Patient Care & Access Must be Performed Prior to Any Expansion:** Given the broad scope of this demonstration and anticipated impact that the program will have on admissions throughout the PAC continuum, AMRPA believes this demonstration should incorporate the same guardrails that apply in other demonstration activity. Most importantly, AMRPA believes that any expansion of the demonstration can only follow a full evaluation of the program's impact on quality of care and access, **and should also have public reporting and disclosure requirements,** similar to the requirements that apply in similarly sized demonstrations.
- **Additional Programmatic Detail & Opportunity for Comment Needed:** Finally, CMS must provide much more specificity about the logistics of the demonstration, including how providers will submit claims, how determinations will be made, how contractors will communicate in a timely manner with providers, and how contractors will be held accountable for performance. AMRPA believes these are critical issues that stakeholders must be able to review and offer input, such that another comment period will be required when CMS ultimately makes these types of determinations.

Our recommendations and the rationale for each of these priorities are detailed more extensively below:

The Demonstration Must be Delayed at Least 1-2 Years after the PHE

While AMRPA believes that the structure of the demonstration will be a threat to patient care and access regardless of its implementation date, the underlying problems with the demonstration will be exacerbated if it is implemented during or in the immediate aftermath of the PHE. As CMS has itself discussed with the Association throughout the pandemic, the PHE has only elevated the need for timely patient access to hospital-level providers and necessitated the multitude of waivers granted to IRFs since March 2020.[7] In fact, CMS just recently issued guidance urging Medicare Advantage (MA) plans to waive prior authorization policies to "facilitate the movement of patients from general acute-care hospitals to post-acute care and other clinically-appropriate settings,"[8] including inpatient rehabilitation hospitals and units. This demonstration appears to run counter to CMS' ongoing efforts to alleviate provider burden wherever possible and facilitate timely access to medically necessary care, making it all the more important that it be delayed until well after the PHE.

[7] The Centers for Medicare and Medicaid Services. (2021, May 24). *Covid-19 emergency declaration blanket waivers for ... - CMS*. COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers. Retrieved October 5, 2021, from https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf.

[8] HPMS Memorandum to All Medicare Advantage Organizations and Medicare-Medicaid Plans; August 20, 2021 (Available for download at https://www.cms.gov/httpseditcmsgovresearch-statistics-data-and-systemscomputer-data-and-systemshpmshpms-memos-archive/hpms-memos-wk-3-august-16-20).

In addition, the waivers and regulatory changes made for the duration of the PHE have in many ways fundamentally changed the medical necessity and documentation requirements for IRF care under the Medicare program. In the CARES Act, Congress eliminated the "3-hour rule" for IRF care for the duration of the current COVID-19 PHE, which significantly altered the medical necessity criteria for IRFs. Typically, the need for (and likelihood to benefit from and ability to tolerate) 3 hours multidisciplinary therapy per day is a crucial component of the determination as to whether a patient meets Medicare medical necessity criteria. Furthermore, given the recognized need for hospital-level access at this stage of the PHE, freestanding IRFs in areas experiencing a surge of COVID-19 patients are exempt from all IRF medical necessity criteria. Beginning a demonstration and reviewing claims based upon temporary medical necessity criteria will do little to determine IRFs expected compliance with the standard medical necessity criteria.

Lastly, but just as important, AMPRA members from across the country continue to report critical-level staffing shortages in both clinical and administrative positions. Through our member outreach, we routinely hear how hospitals are struggling to fill open positions due to a range of issues (e.g., staff burnout; issues tied to vaccination policies), with no clear timeframe as to when or how these issues will be resolved. In fact, AMRPA is aware that a number of states have moved to limit or restrict the use of prior authorization by private insurers in light of these issues involving staff time and resources.[9] Proceeding with a demonstration of this size runs counter to these state efforts to alleviate staffing capacity issues. For all these reasons, CMS must meaningfully evaluate when IRFs will have the capacity to comply with a demonstration of this magnitude, and clarify that the demonstration will not commence for at least 1-2 years after the PHE is declared over.

The Demonstration Must be Significantly Rescaled

CMS proposes to review 100% of Part A IRF claims for all IRFs in selected states for a five-year demonstration period. AMRPA believes the implementation of this proposal would exceed the delegated authority of the agency to develop or demonstrate improved methods for the investigation and prosecution of fraud because the proposal assumes fraud *without first identifying it*. CMS has not cited any specific instances of fraudulent activity to serve as the foundation for developing or demonstrating improved methods for investigating and prosecuting fraud. In addition, CMS has not explained how 100% review of Part A IRF claims would improve on alternatives for investigating and prosecuting fraud, or how state-wide roll-outs would enable such improvement. CMS has not, for example, explained how its proposed dragnet would achieve greater efficiency or deterrence while maintaining or enhancing patient access and health equity. We urge CMS to first identify suspected instances of fraud and then develop a program to investigate and prosecute such activity, consistent with the applicable statute.

These scope-related concerns are amplified by the fact that CMS has numerous other active programs that investigate Medicare claims with much greater precision. For example, the Center for Program Integrity's (CPI's) Targeted Probe & Educate (TPE) program subjects providers to review of a randomly selected sample of claims. After several rounds of review of a sample of claims, a provider that fails to demonstrate compliance is placed under a 100% pre-claim review program. Similar audit programs, such as the Comprehensive Error Rate Testing (CERT) Program, make determinations as to the improper payment rate of an entire field based upon a very small percentage of total claims. In fact, the IRF improper payment rate being used to justify this demonstration reviewed only 530 claims from 2020 out

[9] *See* California Proposed Rule Notice, No. 38-Z, California Regulatory Notice Register pp.1298-1303 (September 17, 2021) (https://oal.ca.gov/wp-content/uploads/sites/166/2021/09/2021-Notice-Register-Number-38-Z-September-17-2021.pdf); New York State Executive Order No. 4, Declaring a Statewide Disaster Emergency Due to Healthcare Staffing Shortages in the State of New York (September 27, 2021) (https://www.governor.ny.gov/sites/default/files/2021-09/EO_4_Disaster.pdf) (Also suspending concurrent and retrospective reviews of claims).

of more than 400,000 IRF claims (approximately one tenth of one percent). AMRPA therefore sees no justification as to why CMS would launch a 100% claims review on providers given their approach in other compliance programs. Those programs are plainly more efficient and less burdensome than the IRF RCD, and there is no reason to believe they are any less effective.

AMRPA was also highly concerned that the IRF RCD materials make only passing reference to the potential impact on patient access, particularly for vulnerable and complex patients. As you are aware, the IRF population is disproportionately comprised of persons with disabilities. Access to IRF care enables Medicare beneficiaries with disabilities to achieve greater levels of health and function after illness or injury than other, less intense settings. IRFs have a high rate of discharging their patients back to their homes and communities to resume their lives and live as independently as possible, enjoying the highest quality of life. In fact, "discharge to community" is one of the key IRF quality measures that underscores the value of intensive, coordinated, interdisciplinary rehabilitation provided in an IRF. The more restrictive CMS and its contractors are with respect to access to IRF care through a demonstration of this magnitude, the more they compromise the goal of health equity for the disability community and the more they undercut their goals with respect to home and community-based care.

AMRPA believes that CPI has the data and the capability to develop a more patient-centered and effective demonstration structure, ideally through collaboration with affected stakeholders. Unfortunately, due to the lack of transparency and without access to the data CPI is using to justify this demonstration, stakeholders are not well-positioned to provide alternative recommendations. As a basic premise, however, AMRPA urges CMS to use objective, measurable, and reliable criteria before subjecting *any* IRF to a claims review of this magnitude. For example, this could include a program similar to TPE, but specific to IRFs, that allows IRFs an opportunity to demonstrate compliance with a subset of claims prior to subjecting them to 100% review. At the very least, the agency could significantly shorten the review period to allow a provider to be excluded from 100% review after a month or less of adequate compliance. In sum, AMRPA strongly urges CMS to revise the scope and design of this demonstration and find an alternative that is far less disruptive to patient access to care on a statewide basis.

Commonsense Refinements are Needed with Respect to Review Timeframes & Other Key Program Features

Regardless of the purported "choice" offered within this demonstration, hospitals will be put in a difficult financial position due to this demonstration – which will ultimately impact patient access. Providers will need to select either post-payment review, and risk the draconian result of forfeiting 100% of their reimbursement for a patient already successfully treated and discharged; or they will need to select a pre-claim review and risk their patients (which are deemed to need medical rehabilitation by their own physicians) being erroneously denied by a contractor after already being admitted to the IRF. Therefore, in order for a pre-claim review to offer a meaningful "choice," it must match the timeliness of hospital operations. As CMS is well-aware, hospitals and their staff maintain operations on a 24 hour, 7 days per week, 365 days a year basis.

Due to the overwhelming clinical evidence of the benefits of timely interventions and detriment caused by delays, IRFs make every effort to admit patients ready for discharge from an acute-care hospital at the soonest available opportunity, and often within hours of the referral. Not only is this necessary to ensure best outcomes for patients, but acute-care hospitals are also under enormous pressure to discharge patients at the soonest available opportunity, and often must discharge to the first post-acute care option that becomes available. For this reason, CMS must ensure there are contractors available around the clock (including weekends) to promptly respond to IRF determination requests - such that contractors provide a response within six hours of receipt. With an average stay of 12.6 days for Medicare beneficiaries, many

patients will be beyond halfway through their treatment when a review determination is provided under the current demonstration structure. CMS provides no guidance, however, as to what will occur if a contractor second guesses a physician's admission decision in this instance. In addition, responding to second and subsequent request submissions within five business days in the IRF RCD's pre-claim track is likewise unworkable and not consistent with CMS' patient care expectations and requirements for IRFs.

Although some hospitals will be able to select the post-payment review option, many simply cannot risk the financial hardship of a loss of 100% of payment for their patients and must be assured of a likelihood of payment prior to or within hours of admission. If CMS fails to offer an accelerated timeframe for review determinations, any purported "choice" offered by this demonstration is simply a difference between post-service review or post-claim review, which offers no meaningful difference to providers. This creates a coercive situation that will force hospitals to begin restricting admissions - *not* because the patient does not need the care, but rather because the hospital cannot tolerate the financial and administrative risk and burden of fighting with the contractor to justify their actions. Put simply, this proposal may force hospitals to act in conflict with what their physicians view as the proper clinical actions. An accelerated set of timelines for review of claims that mirror the exigency of the circumstances in IRF hospitals is critical to avoid these catastrophic access issues for patients in need of medical rehabilitation hospital care.

More Transparency and Accountability Required with Respect to Contractor Qualifications, Training and Oversight

Long before this demonstration was proposed, AMRPA had been in dialogue with CMS and officials within the Center for Program Integrity regarding shortcomings in the qualifications, training and oversight of Medicare contractors that review IRF claims. AMRPA offered a series of recommendations (included as Appendix II) that the field believes would render more accurate and constructive determinations of IRF claim reviews. The field remains certain that many of these shortcomings have contributed to the failure of contractor reviewers. This, in turn, has led to the purported high error rate and the genesis of this proposed demonstration.

AMRPA insists that many of these common-sense improvements must be incorporated into any demonstration aimed at auditing and reviewing IRF rehabilitation physicians' decisions to admit and treat Medicare beneficiaries. The first, and likely most important, reform that CMS must implement is to ensure Medicare contractors are held to a very high standard with regard to clinical qualifications. As the agency knows, only specialized rehabilitation physicians can approve an admission to an IRF under Medicare regulations. Despite this, CMS continues to allow lesser trained clinicians to second guess and override practicing rehabilitation physicians in other IRF audit and review programs. One can look to the Medicare Advantage program for examples of the scope and volume of errors that arise when unqualified reviewers are charged with assessing a service as complex as an inpatient rehabilitation admission. These practices have directly impacted referral patterns and admission decisions and resulted in patients that would have benefitted from inpatient rehabilitation being treated in a different setting because of the anticipated prior authorization rejection or ultimate payment denial. In fact, numerous government oversight reports have found a trend in patients leaving the Medicare Advantage program to enroll in the

traditional Medicare program precisely because of these access issues encountered for services such as inpatient rehabilitation.[10] [11] [12]

While it may be appropriate for nurses or therapists with experience in IRF care to review documentation to ensure all required elements are included, under no circumstance should an clinician other than a physician who meets the Medicare definition of a rehabilitation physician be allowed to determine that a claim was not medically necessary. Any objective measure of the fairness of medical reviews would find that having a clinician without the training and experience of a rehabilitation physician overrule the medical judgement of such a physician to be without merit. In addition, it essentially puts non-physician Medicare contractors in the position of practicing medicine, determining who is admitted for hospital care or not, despite a treating rehabilitation physician attesting to the need for the admission. This raises serious health and safety issues, not to mention legal and ethical concerns, which CMS has failed to adequately address in response to prior comments.

The next crucial improvement that must be made for this demonstration is timely and specific communication on the part of CMS and its contractors. Contractors typically offer very vague reasons for denial, and rarely ever apply the denial reason to the specific facts of the case. For example, in response to a review of a one-hundred-page medical record, contractors often provide single sentence denial reasons, such as "patient did not require close medical supervision by a rehabilitation physician." This type of denial reason is often offered in the face of the physician documenting specific justification for why the patient's conditions required supervision by a physician. However, the denial statements fail to offer any specificity of what the contractor disagreed with regarding the physicians reasoning, or otherwise provide any information that would assist the provider with remedying the purported shortcoming.

For multiple reasons, CMS must vastly improve the quality of communication between contractors and providers. To begin with, providers cannot be expected to have a reasonable opportunity for a redetermination request unless the contractor elaborates substantially on the specifics of the patient that led them to their conclusion. Given the complex nature of IRF patients, and the hundreds of pages of medical records that typically accompany an IRF claim, the only efficient way for contractors to provide sufficient information to providers in a timely manner is to be available for discussions. Particularly when providers choose the pre-claim review option, it would simply take too long for providers and contractors to attempt to dialogue back and forth in writing. Instead, contractors should be available for discussion of the case and their determination immediately after the issuance of their determination. This will ensure that providers can timely rectify any documentation issues and ensure the patient remains able to be treated in a timely fashion. Without this, providers will be left guessing as to what they can do to attempt to secure a favorable redetermination, and a patient may be left without treatment purely due to insufficient contractor communication.

AMRPA also joins other stakeholders in calling for significantly more provider safeguards surrounding the monitoring and oversight of the program. Commonsense measures would include formal and

[10] Momotazur Rahman et al., High-Cost Patients Had Substantial Rates of Leaving Medicare Advantage and Joining Traditional Medicare, 34(10) HEALTH AFF. 1675, 1679-80 (Oct. 2015).
[11] Park, S., Meyers, D. J., & Langellier, B. A. (2021). Rural Enrollees In Medicare Advantage Have Substantial Rates Of Switching To Traditional Medicare: Study examines the rates at which Medicare beneficiaries in rural areas switch between Medicare Advantage plans and traditional Medicare. Health Affairs, 40(3), 469-477.
[12] Government Accountability Office, CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight, GAO-17-393 (April, 2017).

recurring opportunities for IRFs impacted by the demonstration to bring forth concerns with the RCD to both the contractors and CMS officials to better ensure stakeholder issues are conveyed and acted upon. In addition, data from the RCD reviews (as well as concerns lodged by IRFs) should be regularly shared with the field. This will help AMRPA and others identify whether the demonstration is disproportionately impacting access for certain patients (e.g., patients within certain case-mix groups) and engage in appropriate outreach to both CMS and contractors.

Finally, given the apparent widening discrepancy in judgement as to the appropriateness of IRF-level care between experts in the field and Medicare contractors, CMS should convene an advisory board to help bridge this gap. Rehabilitation physicians have continued to act in the best interest of patients when making admission determinations, and yet Medicare contractors often take a very different interpretation of Medicare regulations. Critical to addressing IRF compliance is bringing the two sides together for meaningful discussion and insight. CMS could accomplish this by establishing a medical rehabilitation advisory board, or similar entity made up of individuals focused primarily on inpatient rehabilitation, that would enable experts from the field to share modern best practices with CMS and its contractors. CMS contractors, in turn, could share their understanding of the Medicare regulations and its application to clinical scenarios. This would achieve the "meeting of the minds" that CMS itself has supported in recent communications with AMRPA as a way of collaboratively improving claims review and program integrity.

Evaluation on Patient Care & Access Must be Performed Prior to Any Expansion

For all of the reasons described in earlier sections of this letter, AMRPA believes this demonstration will have direct and significant impacts on the types of patients that are admitted to inpatient rehabilitation hospitals and units. As a result, we believe this demonstration is essentially testing changes to the underlying inpatient rehabilitation benefit in the Part A program. AMRPA therefore recommends that several of the patient and provider-facing protections provided in the context of other CMS demonstration activities must apply in a demonstration of this magnitude.

Of greatest concern to AMRPA, CMS proposes to sequentially expand the demonstration throughout the five-year demonstration period without any reference to how the demonstration will be assessed and evaluated during that time. The proposal simply provides that CMS will implement "the demonstration in Alabama, then expand to Pennsylvania, Texas, and California … [and] [a]fter the initial four states, CMS will expand the demonstration to include the IRFs in any state that bill to Medicare Administrative Contractor (MAC) jurisdictions JJ, JL, JH, and JE." The proposal amounts to a rapid and significant expansion across the nation but makes no reference to whether and how CMS will take account of the program's impact on patient care, patient outcomes, and provider burdens as the demonstration expands to new states – as well as whether the demonstration actually detected fraudulent activity. Given the scope of the proposed demonstration – with respect to both the number of hospitals and units as well as the volume of Part A claims – AMRPA believes that the guardrails that apply in other demonstrations must apply in this program.

As one example, in the context of Center for Medicare and Medicaid Innovation (CMMI) programs, CMS must issue demonstration-specific evaluations and determine that the programs must either reduce spending without reducing the quality of care, or improve the quality of care without increasing spending, and must not deny or limit the coverage or provision of any benefits.[13] With the perceived potential for

[13] 42 U.S.C. § 1315a(c).

care delays and care denials tied to this demonstration, we believe a similar type of review of the program's impact on care quality, outcomes, and benefit access is imperative following the first phase of the demonstration. Consistent with the rules that apply to other similar demonstrations, we believe that CMS' planned expansion (e.g., the proposed roll-out in California, Texas and Pennsylvania) should only proceed if public evaluation reports can demonstrate that the program did not adversely impact patient care. We believe this is a critical yet simple and translatable measure that would align with CMS' goal of initiating a transparent demonstration program.

Additional Programmatic Detail & Opportunity for Comment Needed

In its notice and supplemental materials, CMS has provided a very high-level overview of the proposed demonstration. There are numerous programmatic details that have not been addressed in the notices that will impose substantial obligations on providers, and AMRPA believes that leaving these items to sub-regulatory implementation is inappropriate and contrary to law.

As examples, CMS has not addressed any specifics of how it will require providers to submit determination requests, redetermination requests, submit documentation to providers, and numerous other elements of this demonstration. CMS has also not even stated how long this demonstration will last in each state or region, other than giving an overall estimate for the length of the demonstration. In addition, CMS has not clarified that a claim that is reviewed and approved through the demonstration will not be subject to additional post-service review, save for extreme circumstances.

Lastly, AMRPA believes the burden estimates associated with this program are significantly understated and must be revised based on public comment. Contrary to CMS' estimates of 30 minutes of clerical time to comply with documentation requests under the RCD, AMRPA members estimate this demonstration in many cases will require the hiring of an additional full-time employee(s). CMS' assertion that since the documentation required will only include documentation already required by Medicare, and therefore there will be minimal burden, is not aligned with the administrative requirements of this demonstration. In practice, a staff member will need to be tasked with gathering the documentation required (which is held as part of a larger medical record), complete the process for submitting the request, track and follow up on outstanding requests, dialog with contractors regarding determinations and requests for additional information, dialogue with clinicians regarding the requests for additional information, submit redeterminations, track hospital compliance percentage, liaison with admission managers to determine expected admissions, and numerous other tasks – all of which will be complicated by the inadequate reviewer qualification requirements. Additionally, the most time-consuming aspect of this process will likely be pursuit of appeals at the three major administrative levels of review, redetermination, reconsideration and an Administrative Law Judge hearing. Physicians and therapists are absolutely critical to have involved in these levels of administrative review, but CMS does not currently recognize any of these costs. These factors must be properly considered as part of a burden estimate update, and subject to final stakeholder review to ensure the estimates' accuracy.

These are not nominal details, and how CMS goes about implementing these elements will have a substantial effect on provider obligations and burden, not to mention patient access to care. We therefore assert that additional opportunity to review and comment is critical to achieve CMS' stated goal of working with stakeholders in the development of this demonstration.

****

For the foregoing reasons as well as the arguments raised in our comment letter attached as Appendix I, AMRPA once again requests CMS to withdraw this demonstration project and not pursue its implementation. While AMRPA strongly supports CMS' efforts to ensure compliance in the Medicare program and protect the Medicare trust funds, we believe there are numerous ways that CMS could pursue these important goals without creating serious risks to patient care and outcomes. We stand ready to meet with you, your program integrity staff, and your contractors to engage in a substantive dialogue between clinicians to better identify the foundational elements of our disagreements on the medical necessity of IRF care provided to Medicare beneficiaries, and try to develop a better mutual understanding of the interpretations of IRF coverage requirements. Above all, if CMS decides to press forward with this massive audit demonstration project, we strongly urge the agency to significantly revise the scope of the demonstration to ensure that CMS can achieve its goals without creating debilitating burdens on IRFs and without compromising access to IRF care for the many Medicare beneficiaries who require and qualify for inpatient hospital rehabilitation.

If you have any questions about AMRPA's recommendations, please contact Kate Beller, J.D., AMRPA Executive Vice President for Government Relations and Policy Development (kbeller@amrpa.org / 202-207-1132).

Sincerely,

Anthony Cuzzola
Chair, AMRPA Board of Directors
VP/Administrator, JFK Johnson Rehabilitation Institute

Appendix I

AMRPA Response to IRF RCD Notice 1

February 16, 2021

The Honorable Elizabeth Richter
Acting Administrator
Centers for Medicare and Medicaid Services
Division of Regulations Development
Room C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

RE: Agency Information Collection Activities; Proposed Collection; Comment Request; CMS—10765

Dear Acting Administrator Richter,

On behalf of over 650 freestanding inpatient rehabilitation hospitals and rehabilitation units of acute care general hospitals (referred to by the Centers for Medicare and Medicaid Services (CMS) as "inpatient rehabilitation facilities," or "IRFs")[1], the American Medical Rehabilitation Providers Association (AMRPA) appreciates the opportunity to comment on CMS' inpatient rehabilitation hospital "Review Choice Demonstration." Inpatient rehabilitation hospitals and units furnish intensive and interdisciplinary care for the nation's most complicated and vulnerable patients – such as individuals with spinal cord injuries, stroke, traumatic brain injury (TBI), amputations, neurological conditions, and now survivors of critical illness from COVID-19. **For the reasons outlined in this letter, we primarily ask CMS to fully withdraw this proposal and alternatively engage with AMRPA and other stakeholders to identify more effective and significantly more patient-centered ways to assure Medicare program integrity.**

As hospital-level providers, IRFs play a critical and specialized role for post-acute care (PAC) patients, with a focus on maximizing health, functional skills, independence, and participation in society. Inpatient rehabilitation hospitals have continued to distinguish themselves in the PAC continuum during the current public health emergency (PHE) by delivering highly effective and safe care to COVID-19 survivors and other patients through their clinical competence, physician-led care, and emergency response preparedness. Due to the PHE, which the Acting HHS Secretary has indicated will likely continue through all of 2021, as well as the difficulty some other types of PAC providers have had in providing safe care in the challenging COVID-19 environment, timely access to inpatient rehabilitation services has never been more critical.

[1] The vast majority of our members are Medicare participating providers. In 2018, IRFs served 364,000 Medicare beneficiaries with more than 408,000 IRF stays.

Anthony Cuzzola · Chair, AMRPA Board of Directors
Vice President/Administrator, JFK Johnson Rehabilitation Institute
529 14th Street NW, Suite 1280, Washington, DC 20045 · Phone: 202-591-2469 · Fax: 202-591-2445

AMRPA is therefore alarmed by CMS' proposal to initiate an "IRF Review Choice Demonstration," which, as proposed, presents serious risks to both patients and AMRPA member hospitals. As announced under the prior Administration in mid-December 2020, CMS is proposing to subject IRFs in select states to either 100% pre-claim or post-payment review for all admissions. Per CMS' materials, the audits will focus on compliance with Medicare coverage rules and clinical documentation requirements, and nurse reviewers will be charged with reviewing claims for compliance with Medicare coverage and documentation requirements. Hospitals will remain subject to the demonstration until it is determined that the hospital has reached a compliance threshold of at least 90 percent. CMS states that the purpose of this demonstration is to "improve methods for the identification, investigation, and prosecution of potential Medicare fraud."

Overall, this proposed demonstration would jeopardize patient access to comprehensive, intensive, and interdisciplinary inpatient rehabilitation and patient-centered post-acute care, and in many ways reflects a misunderstanding of the value of IRF services. As CMS is well aware, Medicare regulations specifically require that every Medicare beneficiary admitted to an IRF be approved by a rehabilitation physician. This determination occurs through the rehabilitation physician applying specific IRF payment and coverage rules to the unique complexities and circumstances of each individual patient and her or his particular medical and rehabilitative care needs.[2] As proposed, the demonstration would require nurse reviewers to second-guess the medical necessity determinations of specialized physicians who have extensive experience and expertise in medical rehabilitation. Ultimately, this structure will force IRFs to turn away patients for whom they would likely experience disagreements with auditors (based on AMRPA members' past experiences), particularly given the fact that the scope of the demonstration will limit the extent they can endure the time-intensive and labor-intensive appeals process. Furthermore, small units (often with negative Medicare margins) could be forced to close, which is precisely what occurred in select states during CMS' Recovery Audit Contractor (RAC) pilot program. Even more concerning, CMS does not propose any sort of separate, expedited appeals process for IRF claims under this demonstration program, potentially subjecting hospitals to erroneous coverage denials. These and other operational issues put patients in a precarious situation of facing care disruptions and coverage uncertainty.

Furthermore, under the materials released, CMS repeatedly points to the similarities between this demonstration and the one implemented for home health agencies.[3] However, AMRPA urges CMS to take note of the vast differences between these two settings of care that render a similar demonstration impractical on several levels. Unlike home health patients, who must be homebound, IRF patients are in need of *hospital-level* care and determined to need such care by specialized physicians. The need for hospital-level and physician-driven care makes IRF

[2] See 42 C.F.R. § 412.622(a). Among other requirements, a rehabilitation physician must review and concur with all admission determinations on a pre-admission screening, the patient must need an interdisciplinary approach to care and be stable enough at admission to participate in intensive rehabilitation. There must also be a "reasonable expectation" that the patient will need multidisciplinary therapy, intensive rehabilitation, and supervision by a rehabilitation physician. The requirement for multidisciplinary therapy must include physical or occupational therapy. Intensive rehabilitation is defined as three hours per day, five days per week (or 15 hours per week). The therapy must be reasonably likely to result in measurable, practical improvement to the patient's functional capacity or adaptation to impairments. The rehabilitation physician must see the patient at least three times per week.

[3] CMS continues to administer the "Review Choice Demonstration for Home Health Services," which bears similarity in both name and structure to the demonstration proposed for inpatient rehabilitation.

patients among the most medically complex and fragile Medicare beneficiaries, and in no way comparable to those that can be cared for through home health services. AMRPA soundly disagrees that the outcomes of the demonstration in the home health space would in any way translate to inpatient hospital rehabilitation. To the contrary, we believe a demonstration akin to the home health demonstration project applied to IRF care would directly result in delays and erroneous denials for patients in need of intensive inpatient rehabilitation.

We therefore urge CMS to fully withdraw this proposal and instead engage with AMRPA and other stakeholders to identify more effective and patient-centered ways to evaluate Medicare compliance with medical necessity and documentation requirements.

If CMS nonetheless goes forward with a demonstration, there must be vast reforms made to the currently proposed demonstration structure. First, given the critical role IRFs are playing during the pandemic and will continue to play in years to come, especially for long-term COVID-19 patients (so-called COVID-19 "long-haulers"), CMS must delay any implementation of this program for at least two years after the end of the PHE. Just as importantly, AMRPA urges CMS to take a more limited approach to the demonstration's roll-out, rather than subjecting 100% of IRF patients in select states to potential access issues and care delays and reviewing all of an IRF's traditional Medicare claims. Lastly, AMRPA believes significant alterations are needed to the demonstration itself to protect both patients and our member hospitals, such as more appropriate reviewer qualification standards and revised burden estimates. A summary of our key recommendations follow:

Summary of AMRPA's Response:

1. This demonstration should be withdrawn given that it is likely to result in serious access limitations for Medicare beneficiaries in need of hospital-level rehabilitation. The programmatic impracticalities of such a demonstration, such as use of unqualified reviewers, extended turnaround time for claim determinations, lack of an expedited appeals process, and several other program elements discussed herein would ultimately harm patients and cost Medicare more money due to subpar long-term outcomes.
2. This demonstration will be substantially more burdensome and costly for IRFs than CMS estimates, particularly the cost for hospitals to comply with these novel requirements and processes. CMS must therefore revisit its estimates and ultimately its determination that such a demonstration is in the best interest of Medicare beneficiaries and the Medicare program (as well as already-overburdened Medicare contractors) after considering these factors.
3. Given the ongoing PHE and the long "tail" impact this pandemic will have on rehabilitation hospitals, any demonstration should be delayed for at least two years beyond the end of the PHE.

If after these considerations CMS proceeds with a demonstration, we provide the following additional points.

1. Of critical importance, CMS must significantly scale back the number of IRFs subject to the demonstration to avoid state-wide IRF patient access issues and care disruptions. As proposed, this demonstration will force IRFs to turn away patients who are appropriate for (and would benefit from) inpatient rehabilitation but pose a risk of erroneous denial due to the substandard reviewer qualifications. Further, the administrative and financial risk will force many smaller and rural IRFs to close, exacerbating access issues in underserved areas. Even more concerning, CMS does not propose any sort of separate, expedited appeals process for IRF claims under this demonstration program, potentially subjecting hospitals to erroneous coverage denials. These and other operational issues put patients in a precarious situation of facing care disruptions and coverage uncertainty. By taking a state-wide approach, CMS would subject providers to onerous reporting requirements and effectively force them to divert time and resources from patient care – all without any consideration of providers' compliance with Medicare rules. AMRPA therefore implores CMS to employ a more data-driven, limited approach to selecting IRFs for this demonstration, taking into account patient access to care in a given area and metrics that *accurately* reflect a provider's true compliance record (for example, taking into account claims overturned in favor of the provider by external reviewers).
2. In addition to addressing the scope of providers subject to the demonstration, CMS should also take a much more limited approach with respect to the volume of claims under review. AMRPA urges CMS to review only a limited sample of claims, through which CMS could effectively determine whether a particular IRF should receive additional education or review. This approach would avoid the burdensome 100% claim review approach, which AMRPA views as excessive, burdensome and not needed.
3. Additional safeguards are crucial to ensure there is not a negative impact on beneficiary access and patient care. These include requiring that the contractors use trained rehabilitation physicians to review IRF claims, ensuring pre-claim determinations are returned within 12 hours, 24/7 staffing at participating Medicare Administrative Contractors (MACs) to limit the negative impact on patient care, an expedited appeals process to prevent lengthy delays in resolving disputes, and a careful reconsideration of the sufficiency of documentation needed for MACs to make their determinations.
4. The justification for this demonstration relies on faulty prior audits by underqualified reviewers. CMS should therefore consider undertaking a project with AMRPA and/or other stakeholders to review a sample of IRF claims to discuss why there are fundamental discrepancies between treating rehabilitation physicians and CMS auditor conclusions. This will enable CMS to employ a significantly more focused approach to improving program integrity.

The remainder of this letter contains a comprehensive discussion of AMRPA's concerns in more detail. We appreciate your consideration and look forward to continued engagement with CMS on this critical issue.

THE DEMONSTRATION RAISES SERIOUS RISKS OF DISRUPTING AND DENYING BENEFICIARY ACCESS TO CARE

AMRPA respectfully yet strongly disagrees with CMS' assertion that the proposal will not affect beneficiary access to timely care. In either the pre-claim review or post-claim review process, there are substantial risks created by this demonstration that will impact patient care. As CMS is aware, IRF admissions are required by regulation to be approved by physicians with experience and expertise in rehabilitation, taking into account the significant complexity of the patients treated by IRFs and the myriad of coverage and payment rules that apply to IRFs. As proposed, the demonstration would require nurse reviewers to second-guess the medical necessity determination of physicians with years of experience and expertise in medical rehabilitation. Although CMS states that these nurse reviewers will be trained, any training will not match the education and experience of rehabilitation physicians. The use of nurse reviewers or other qualified personnel has very likely led to a high rate of erroneous denials from Medicare contractors in past audits and would lead to similarly incorrect denials in the proposed demonstration.[4]

To illustrate the problem for an IRF choosing the pre-claim review option, an IRF will often receive a referral for an admission for a hospitalized patient at an acute care hospital (ACH) approximately one to four days prior to the patient's discharge date from the ACH. Per CMS regulations, within 48 hours prior to the IRF admission, a rehabilitation physician must review and concur with the decision to admit the patient. Then, the rehabilitation physician will need to complete the Individualized Overall Plan of Care (IOPC) after admission to the IRF before submitting the pre-claim review request. Under current Medicare regulations, the physician has four days to complete the IOPC after having an opportunity to examine and treat the patient, and to consult with the rest of the interdisciplinary treatment team. With a proposed MAC deadline of five business days to respond to the pre-claim review, it may be seven to 11 days *after admission* before the IRF receives a response from the MAC.[5] This timeline is unacceptable for the responsible treatment of IRF patients who, once engaged in an IRF intensive therapy regimen, would risk harm to their health by stopping suddenly.

The average length of stay for a Medicare IRF patient is 12.7 days. IRFs that utilize the pre-claim review option, therefore, will likely begin receiving denials no sooner than halfway through the usual patient's stay, if not close to or after the patient is discharged. For those patients that are still being treated when the MAC's denial arrives, the IRF will be placed in the impossible position of either deciding to continue treating the patient, or putting the patient through a harmful disruption of care by discharging them in the midst of treatment.[6]

---

[4] In 2019, CMS agreed to a global settlement to pay IRFs 69% of all pending appeals of IRF claim denials. This was the highest percentage paid in a global settlement by CMS. This high settlement percentage strongly suggest that CMS' contractors are not appropriately qualified to reach admission decisions for IRF patients. In addition, it is very likely that the percentage of incorrectly denied claims was much higher and that IRFs accepted the settlement percentages in order to avoid the cost, delay, and uncertainty of the appeals process.

[5] Five business days, including weekends, would be seven days after admission unless the request is submitted on a Monday. If it takes the IRF four days to complete the IOPC, it would be 11 days after admission until a decision is returned. As discussed further below, hospitals operate 24 hours per day, 365 days per week, and Medicare contractors reviewing hospital admissions of this magnitude should be available around-the-clock to review claims.

[6] The hospital is also prohibited from immediately discharging the patient under current Medicare regulations at 42 C.F.R. Subpart J. These CMS regulations requires the hospital provide adequate notice to a patient prior to being discharged and the

Compounding these issues, CMS does not propose any sort of separate, expedited appeals process for IRFs, thereby providing no recourse to hospitals and patients receiving erroneous coverage denials from unqualified reviewers. Instead, hospitals would be forced to face a years-long appeals process to receive reimbursement for each claim if they choose to continue to treat the patient.[7] Pressing forward with 100% IRF claim review in the face of a seriously backlogged administrative appeals system will dramatically increase the Administrative Law Judge (ALJ) hearing backlog.[8] With no reasonable availability of a timely third-party, independent adjudication, IRFs will be in the unenviable position of either waiting for years for an opportunity to defend the admission decision rendered by a physician, or changing their admission patterns to deny patients access to care they otherwise believe squarely qualify for IRF coverage. This creates a "gatekeeper" effect that will directly restrict IRF admissions for Medicare beneficiaries that are entitled to – and most importantly, would benefit from - this level of care.

While CMS purports to provide choice in how a hospital participates in the demonstration through either a pre- or post-claim review option, both options put patients and providers in a precarious position. Even if hospitals choose the post-claim review option, this demonstration creates tremendous financial uncertainty and risk for IRFs, which ultimately will be reflected in patient admissions at the front end of the process, without any due process. Despite claims citing high topline IRF Medicare margins, a closer examination reveals that many IRFs would likely be unable to sustain the financial uncertainty created by this demonstration. Analysis of Medicare payments shows that 34 percent of all IRFs have negative Medicare margins, and 42 percent have margins below five percent.[9] Further, Medicare fee-for-service payments make up approximately 60 percent of all IRF discharges.[10] It will be simply unsustainable for a provider to risk having such a significant percent of its overall revenue withheld while it goes through a years-long appeals process, and will force IRFs to restrict admissions for medically appropriate, severely debilitated Medicare beneficiaries due to the risk of insolvency.

AMRPA has closely tracked the roll-out of the similarly structured home health demonstration and, particularly in the early phases, we learned that smaller and rural providers could not undertake the risk of providing services given concerns with erroneous claim denials. We believe IRFs will experience the same impacts under the current demonstration model, and have also noted that Medicare margins are even lower for rural and unit-based IRFs, which will create an extraordinarily disparate impact on rural and smaller hospitals.

---

patient must be afforded the opportunity to appeal the discharge determination prior to being discharged. In addition, hospitals must ensure a safe discharge disposition for patients. Finding a sub-acute placement for a seriously impaired rehabilitation patient can sometimes take a up to a week, especially during the current COVID-19 PHE.

[7] As of the end of the third quarter of 2020, nearly half of the appeals in the backlog (201,292) as of the U.S. District Court for the District of Columbia's mandamus order to the Department of Health and Human Services to reduce the appeals backlog remain pending. Defendant's Status Report dated September 24, 2020, *Am. Hosp. Ass'n v. Azar*, Civil Action No. 14-851 (JEB) (D.D.C. Nov. 1, 2018).

[8] This action would also be counter to the Federal Court mandamus order issued in American Hospital Association v. Azar *Am. Hosp. Ass'n v. Azar*, Civil Action No. 14-851 (JEB) (D.D.C. Nov. 1, 2018).

[9] Analysis of IRF rate setting files released by CMS.

[10] Medicare Payment Advisory Commission (MedPAC), Report to the Congress: Medicare Payment Policy, Chapter 10: Inpatient rehabilitation facility services (March 2020).

Likewise, this demonstration also puts ACHs in a difficult position as they learn of the risk created by this demonstration. These upstream providers will need to choose between referring to the appropriate level of intensive care, but with a risk of care disruption, or a less appropriate setting of care, without the risk of care disruption. The long-term outcomes for Medicare beneficiaries may suffer as ACHs become hesitant to refer patients to IRFs. In the long-term, the demonstration would seriously imperil communities that are already struggling with adequate access to inpatient rehabilitation care, compromising the quality of care and long-term outcomes for patients in the Medicare program.

Collectively, these programmatic issues put patients in a precarious situation of facing care disruptions and coverage uncertainty. These concerns are significantly heightened for inpatient rehabilitation hospitals given the complexity of the patients needing IRF care and the impact of care delays on long-term outcomes. **We therefore urge CMS to fully withdraw this proposal and alternatively engage with AMRPA and other stakeholders to identify more effective and patient-centered ways to assure Medicare program integrity.**

CMS ENORMOUSLY UNDERESTIMATES THE BURDEN ON IRFS FOR THIS DEMONSTRATION

CMS estimates that each claim will only take an IRF an average of 30 minutes to process, utilizing personnel at an hourly wage of $17.13 per hour and a fully loaded cost of approximately $34 per hour when including fringe benefits and other overhead. Based on AMRPA members' experience and expectations, this is a vast underestimation of the cost that will be borne by hospitals for this type of demonstration. CMS failed to consider multiple factors in its burden estimate, including the level of personnel needed for these requirements, the time and expense needed to implement the new processes, time spent tracking ongoing claim requests, expected appeals, and adjustments hospitals will need to make due to the financial implications of this demonstration.

First, hospitals would *not* utilize entry-level staff making approximately $34,000 annually to handle the important task of ensuring proper submission of complex claims and records to CMS. This type of work will require the oversight and training of more senior personnel with experience in post-acute care and Medicare payment processes. The hospital will also need expend time and considerable resources to design new systems and processes to ensure proper submission of these claims in accordance with these novel requirements. Further, once claims are submitted, hospitals will need to maintain a tracking system and continuously update its new processes based on the results of claim submissions. For several departments of IRFs, this will be an "all hands on-deck" demonstration, that will average far more than 30 minutes per claim, at a cost substantially higher than $34 per hour.

Beyond just the runway and continuous submission and tracking of claims, hospitals can expect a litany of other expenses due to this demonstration. As explained further within this letter, hospitals can expect to receive erroneous denials during this demonstration. Even a single appeal of an incorrectly denied claim can be very costly for an IRF. The IRF will need to utilize the time of physicians and other specialized clinicians to appeal the claim through multiple levels of appeals, which is all expense the hospital cannot recover when it ultimately prevails at the higher level of appeals. As also expanded upon further in this letter, this demonstration will put IRFs at substantial financial risk. Hospitals will need to expend considerable resources forecasting the

implications of this demonstration on its financial outlook, develop several contingencies depending on the various outcomes, and continuously re-evaluate the impact of the demonstration to determine needed adjustments to the hospital operations.

Based on these factors, we ask that CMS conduct a full re-evaluation and reconsideration of this demonstration. Placing such a substantial burden is not in the best interests of hospitals, Medicare, and most importantly patients, especially when there are far less disruptive alternatives available to CMS.

IF NOT WITHDRAWN, CMS MUST DELAY THE DEMONSTRATION UNTIL AT LEAST TWO YEARS AFTER THE PUBLIC HEALTH EMERGENCY ENDS

CMS has certainly recognized the value of IRFs during the pandemic. IRFs have allowed patients to receive timely, safe and effective care and provide a vital source of hospital-level care in communities facing surges. For much of 2020, CMS worked closely with AMRPA and other stakeholders to *reduce*, where possible, IRF-specific documentation and reporting requirements. Through these waivers, IRFs have undertaken considerable operational changes, ranging from new uses of telehealth, to providing medical management to patients unable to be treated in acute-care hospitals. The proposed demonstration would now take a step in the opposite direction, subjecting IRFs to claims review and potential follow-up from MAC reviewers during or after every patient stay. The PHE was not even referenced in any section of the demonstration materials despite CMS' close engagement with the field and clear understanding with the respect to the need to reduce administrative burden.

In addition to our concerns with the special burdens created by this demonstration under the PHE, it is also infeasible to initiate the demonstration when so many waivers apply to IRF admission and stays during the PHE. The complexity of reviewing PHE-period claims is already evidenced by the questions raised at the outset of the 60% rule waiver and its impact on presumptive compliance reviews. Requiring nurse reviewers to navigate the waivers that apply to IRF claims on top of a review of medical necessity increases the already-heightened risk of erroneous claim reviews.

Lastly, AMRPA has discussed the importance of ensuring that IRF COVID-19 waivers remain in place well after the PHE is declared over. IRFs will be a critical provider of the complex care and rehabilitation needed by many COVID-19 "long-haulers," which in turn will require an extension of waivers such as the 3-hour rule and 60% rule waivers. It is therefore important to not only delay this demonstration until after the PHE is lifted, but also until after the PHE waivers are deliberately and appropriately scaled back. Furthermore, a demonstration could only feasibly be initiated after IRFs have had time to adjust to the new operational environment (with a number of new and permanent regulatory changes following the PHE) and have improved their operational capacity. **For all these reasons, we believe that CMS could not practically start this demonstration until <u>at least two years</u> after the PHE is declared over. We further urge CMS to closely engage with AMRPA and other stakeholders to determine an appropriate initiation timeframe following the official end of the PHE.**

CMS MUST CONSIDER ALTERNATIVES TO THE STATE-BASED IMPLEMENTATION MODEL AND EMPLOY A MORE LIMITED APPROACH TO CLAIMS REVIEW TO AVOID PATIENT HARM & POTENTIAL CLOSURES

As AMRPA has conveyed to CMS, our hospitals have always supported efforts by the Department of Health and Human Services (HHS) and others to identify and reduce fraud, waste and abuse in the Medicare program and improve program integrity. However, this proposed demonstration will subject all IRF providers to significant additional documentation and reporting requirements *without any evidence that these providers have engaged in fraudulent behavior*. In addition, the proposed structure seems to fall well outside the scope of traditional "demonstrations" that test new types of payment or coverage mechanisms, rather than rolling out massive operational changes to every provider in select states. Although AMRPA disagrees with CMS's apparent conclusion that a demonstration of this nature is needed, if CMS proceeds we urge it to be more in line with a typical "demonstration" by being considerably more limited and precise in its approach. AMRPA therefore recommends that CMS employ a more focused to selecting both the IRFs subject to a demonstration and the volume of claims reviewed from those selected IRFs, as we outline below.

First, in line with a true "demonstration," CMS must employ a much more limited approach with respect to the number of IRFs subject to the contractors' review. By utilizing a state-wide roll-out, CMS will subject providers to a tremendously burdensome claims review process with no consideration of the individual hospital's program integrity performance. Most importantly, patients in need of critical and timely inpatient rehabilitation services will face access issues and care disruptions given the likelihood of inaccurate claims reviews (we discuss this issue in more detail in our reviewer qualification section). When CMS employed a similar state-based implementation in its initial RAC pilot program, it led directly to the closure of smaller IRFs in those states. AMRPA fears the same outcome will result from this program despite the intensified need for IRF access with the long-term PHE aftermath.

In addition to the potential operational impact on AMRPA members, the demonstration will also negatively impact referral and admission decisions, in direct conflict with CMS' stated goal of promoting patient-centered care. Instead, this demonstration will force many IRFs to turn away patients in need of medically necessary inpatient rehabilitation but pose a risk of erroneous denials due to the inappropriate reviewer qualifications. As a result, the demonstration will effectively force many patients in those states into an inappropriate PAC setting, heightening the risk of complications and readmissions while increasing long-term costs to the Medicare program.

AMRPA therefore urges CMS to withdraw its proposed state-based implementation and instead utilize an evidence-based approach in selecting IRFs for this demonstration. While AMRPA would welcome the opportunity to discuss this type of approach with CMS, such measure would, at minimum, take into account patients' geographic-based access to inpatient rehabilitation and metrics that accurately reflect a hospital's compliance with Medicare requirements. We stand ready to work with CMS in identifying a more focused approach to implementation that would both reduce the number of providers (and patients) subject to this problematic initiative in order to more accurately and precisely address the risks CMS wishes to solve.

In addition to taking a more limited approach with respect to the IRFs subject to the demonstration, CMS must lower the percentage of claims reviewed. CMS regularly conducts audits based on very small percentage of claims, including in the Comprehensive Error Rate Testing (CERT) program, which is used as justification for this demonstration. AMRPA sees no reason why CMS could not gain legitimate insight into provider satisfaction of medical necessity and documentation requirements from a random sampling of a small percentage of a provider's claims. Through these probe audits, CMS could then determine whether a provider should be subjected to a higher percentage of claim reviews.

Instead, CMS has taken the opposite approach, burdening many hospitals that may have high compliance rates with reviews of 100% of their IRF claims. **AMRPA therefore urges CMS to revise the demonstration with a limited application and develop improvements around its medical audit practices and procedures pertaining to IRF services.**

IF CMS MOVES FORWARD WITH THIS DEMONSTRATION, NUMEROUS AND SIGNIFICANT SAFEGUARDS ARE NEEDED TO PROTECT PATIENT ACCESS TO INPATIENT REHABILITATION SERVICES

As discussed above, the structure of this proposed demonstration creates serious risk of harm to patient access and the ability of IRFs to continue to deliver high-quality care to Medicare beneficiaries. Although some of these risks cannot be fully mitigated, AMRPA believes there are several essential steps CMS must take if it opts to move forward. These include improving reviewer qualification standards, accelerating the timeframe of reviews, an expedited appeals process, and others.

CMS Must Use Qualified Rehabilitation Physicians to Review Claims

To start, CMS must use qualified rehabilitation physicians to review the admission judgements of other rehabilitation physicians. Given the medically complex nature of IRF patients, CMS justifiably requires IRFs to utilize highly-qualified rehabilitation physicians to review and approve all IRF admissions. AMRPA therefore questions why CMS would recognize the physician-level skills and training needed to make these admissions decisions through regulatory requirements, and then rely on nurses to conduct the proposed reviews.

Nurses, not to mention most physicians, plainly do not meet CMS' expertise standards for approving an IRF admission. Just six months ago, CMS reiterated the crucial role the training and experience of rehabilitation physicians plays in the admission and care for IRF patients. In that final rule, CMS rejected a proposal to allow lesser-trained clinicians to step into the role of the rehabilitation physician in order to ensure "that the vulnerable IRF populations will continue to receive the highest quality of care for their post-acute rehabilitation needs."[11] CMS went on to say that ensuring only rehabilitation physicians make these critical judgements "preserves the existing benefit structure of the IRF setting, ensures the quality of care for IRF patients by continuing the rehabilitation physician's close involvement in the establishment of the patient's plan of care and the initial implementation of the plan of care."[12]

[11] 85 Fed. Reg. 48,452.
[12] *Id.*

AMRPA members have been very engaged with respect to the accuracy of Medicare contractor reviews and the validity of program integrity reports issued by HHS and others. **Based on these industry experiences, and CMS' own affirmation of the unique qualifications of rehabilitation physicians, it is vital that CMS only utilize rehabilitation physicians that meet CMS' definition of a rehabilitation physician to issue decisions regarding medical necessity.** Absent this, CMS cannot have any reasonable expectation that its reviewers are reaching appropriate determinations on these claims, and should expect erroneous denials, multiple appeals, and disruptions in access to care.

CMS Needs to Implement a Vastly Accelerated Timeframe for Pre-claim Reviews

Given the substantial risk IRFs will be exposed to through this demonstration, if CMS proceeds with this demonstration, providers must have the option of pre- or post-claim review, despite this choice providing only minimal relief. For providers choosing pre-claim reviews, IRFs will likely undergo the difficult experience of receiving determinations during the course of treatment, and may be forced to discharge patients after a denial, creating major disruptions in care, but perhaps limiting their financial liability for the care being provided. Alternatively, providers could choose post-claim reviews, where they will have provided the full course of treatment and bear the entirety of the financial burden for the care, but at least will avoid mid-treatment care disruptions for their patients.

While it is vital that providers have a choice between these options to ensure continuity of operations, for pre-claim reviews, allowing MACs five business days to offer an initial decision is entirely impractical. Unlike other provider types, such as home health agencies, IRFs are hospitals and operate 24-hours per day, 365 days per year. Requests for IRF admission come at all times during the day or night with no regard for weekends, holidays, or other business operations. This is because, unlike other settings of care, *hospital-level care* requires immediate and continuous intervention, with doctors and nurses working around the clock to care for patients.

When a patient is admitted to an IRF, care typically begins immediately, and does not pause for evenings, weekends, or holidays. As illustrated earlier, permitting MACs five business days to return a decision means patients will be at least halfway through their IRF course of treatment before a decision in rendered. This is not a meaningful opportunity for the IRF to have their claim reviewed prior to putting significant resources towards care and treatment of a patient. **In order to do that, a MAC must be able to return a claim decision within hours, and in no event longer than 12 hours after the claim request has been submitted.** Even if the claim is returned within 12 hours of the time the request is submitted, the patient is still likely to have undergone approximately two to four days of treatment, and the hospital will still be forced to grapple with the risks of an early discharge, despite the fact that the negative financial impact will be somewhat lessened.

In addition, we emphasize to CMS that unlike other provider types, who may be able to delay care until a pre-claim review is completed, delaying care is never an option for IRF

beneficiaries. A cohort of research clearly demonstrates the negative effects on delaying rehabilitation interventions for seriously compromised IRF beneficiaries, and AMRPA clinicians can provide CMS with greater detail on the effects of delayed care for these patients.

CMS Must Implement a Separate and Accelerated Appeals Process for Demonstration Claims

According to the Office of Medicare Hearings and Appeals (OMHA), the current delay in providers receiving an appeals hearing for denied Medicare claims is 1,447.6 days.[13] In fact, the most recent status report from HHS suggests the ALJ backlog is more than 200,000 cases.[14] Despite overturning appeals in favor of IRF providers at a very high rate, many IRFs struggle financially with unpaid claims while awaiting a hearing to receive their reimbursement for an erroneously denied claim. This was the case even when audits of individual hospitals consisted of 20-40 claims for the entire year. In this demonstration, providers could be subject to denial for 100% of their claims for at least a six-month period, which puts them at exponentially greater financial exposure than is already experienced. This demonstration also portends a massive influx of new claims to the administrative appeals system, complicating efforts for HHS to comply with the court-ordered writ of mandamus instructing HHS to clear the ALJ backlog by 2022.[15] This will also dramatically expand the amount of time it takes OMHA to hear appeals and make decisions on those claims, in further violation of the statutorily-mandated 90-day deadline for these decisions.[16]

The stark truth is that many IRFs simply will not be able to remain solvent if they need to wait years to receive fair hearings for their denied claims. Unlike home health agencies or other settings, where providers may be able to delay initiating care prior to receiving a pre-claim determination, delay is not an option for the timely, hospital-level care needed by inpatient rehabilitation hospital patients. Even for pre-claim reviews, providers will already have devoted substantial resources towards patient care once a determination is reached. **These providers must be afforded the prompt opportunity to appeal their cases. These appeal remedies must be available immediately, and take place within hours, not days.**

CMS Must Clarify and More Carefully Consider Documentation Requirements for Claim Reviews

AMRPA urges CMS to provide clearer and more streamlined documentation requirements for these reviews, and to also carefully consider whether the documentation currently listed in the information collection is adequate. First, it is unclear to AMRPA what some of the documentation listed consists of, and for other elements, it is unclear why it is included. CMS lists a post-admission physician evaluation (PAPE) as a required documentation element, but the PAPE was regulatorily eliminated by CMS, effective October 2020. In addition, CMS lists an "overall plan of care," separate from

[13] *See* https://www.hhs.gov/about/agencies/omha/about/current-workload/average-processing-time-by-fiscal-year/index.html.
[14] Defendant's Status Report dated September 24, 2020, *Am. Hosp. Ass'n v. Azar*, Civil Action No. 14-851 (JEB) (D.D.C. Nov. 1, 2018).
[15] *Am. Hosp. Ass'n v. Azar*, Civil Action No. 14-851 (JEB) (D.D.C. Nov. 1, 2018).
[16] *See* 42 U.S.C. § 1395ff(d)(1)(A).

an Individualized Overall Plan of Care (IOPC); the latter document is a regulatorily required element, but AMRPA is unclear what the former document references. CMS also states that the pre-admission screening must include elements that are not regulatorily required, such as an explanation for why conditions causing the need for rehabilitation require physician supervision – which has never been required on the pre-admission screen. Without clarification, the demonstration could lead to greater confusion across the industry rather than servicing to improve proper claims.

Beyond clarifying the documentation elements that will be required, CMS should carefully consider whether and what types of documentation should be required to be submitted in light of the massive scope of the demonstration (100% of all traditional Medicare patients in IRFs subject to the demonstration). As detailed in our burden estimate section, AMRPA believes CMS has vastly underestimated the time and expense that will face hospitals as they seek to comply with the demonstration. It is therefore essential that CMS streamline the documentation requirements required under the demonstration to the extent it can effectively do so.

CMS Must Include Additional Transparency and Communication Standards Between Contractors, Providers and CMS

As proposed, CMS does not include any means by which the progress and outcomes of the demonstration can be monitored. Given the high-risk nature of this demonstration for patients, providers and CMS, it is essential that all stakeholders have adequate insight into the demonstration. To accomplish this, CMS must ensure contractors provide a litany of vital information to providers during the course of the demonstration. Among other items, this should include at least a weekly, detailed tabulation of a provider's compliance rate under the demonstration. This will allow IRFs to closely monitor their progress and quickly address any issues that have arisen. In addition, CMS should specify precise criteria it will use to calculate error rates, and how those error rates will be adjusted on a rolling basis to account for appeal outcomes and other factors.

It is also vital that contractors be required to provide detailed and specific rationale for all denied claims. This must go beyond just citing a rule or regulation and must include an application of the specific patient circumstances to the Medicare standard in question, explaining why the expert reviewer does not agree with the rehabilitation physicians' judgement. As with the decision itself, this information must be provided promptly to the provider so that it can adequately respond. Without this and other information, providers will be left in the dark about their progress under the demonstration, leaving them unable to meet any shortcomings that might be identified.

Additionally, CMS has described no sort of "check" or "review-the-reviewer" feature that would help guard against this concerning risk. In the past, MACs have denied IRF claims for illegitimate reasons, such as whether a particular patient could have also been treated in a SNF. CMS has had to clarify this precise point with MACs in the past, yet the proposed demonstration features no MAC oversight function to ensure these types of erroneous review decisions do not occur. To help with this effort, CMS should make available all instructions to MACs for undertaking of this review in order to allow for feedback from practitioners in the field. This increased level of transparency would ensure

that auditors and practitioners share the same expectations of medical necessity for IRF services.

THIS DEMONSTRATION IS UNLIKELY TO ACHIEVE CMS' STATED GOALS

AMPRA questions the underlying premise for the demonstration and would like to work with CMS to explore other more limited ways to assess concerns with the IRF payment system. CMS has stated that the goal of this demonstration is to "assist in developing improved procedures for the identification, investigation, and prosecution of potential Medicare fraud." CMS cites the purportedly high improper payment rate for IRFs in the Medicare fee-for-service program as justification for targeting IRF services for such a review, although CMS fails to distinguish between improper payments and fraud, which are two wholly separate matters. On the latter, AMRPA's review of the demonstration materials finds no cited evidence of fraudulent activities. We therefore assume the demonstration is premised on the improper payment rate, which is determined by a small sampling of claims each year conducted by Medicare contractors under CERT program.[17] AMRPA has long questioned the methodology and validity of these figures for several reasons.

First and foremost, the CERT utilizes lesser-trained reviewers that second-guess the medical judgment of treating rehabilitation physicians, based solely on written medical records, just as this demonstration proposes to do. As CMS knows, the admission decision to an IRF is medically complex, requiring the judgment of one, if not multiple, qualified physicians. Yet CMS' approach to audits brushes this aside, opting for less costly reviewers, but an ultimately deficient approach to medical necessity determinations utilizing nurses who do not have specialized medical training. Further, in meetings with CMS personnel overseeing the CERT program, they cited an erroneous "goldilocks" standard for IRF admissions, raising serious concerns that there has been a fundamental misunderstanding in the coverage criteria to be applied to IRF services.

Even more unfortunate, the improper payment figures published by the CERT do not account for successful appeals of these CERT determinations, which, due to the ALJ backlog, often occur years after the CERT report is published. Due to lesser-qualified reviewers, IRF claims are overturned at an extremely high rate. This high IRF reversal rate is reflected in the 2019 global settlement CMS offered the IRF industry. The settlement percentage on each case was the highest ever agreed to by CMS, including a 100% repayment rate for certain IRF cases.[18] A 100% settlement percentage is a tacit admission that CMS contractors simply decided many of these cases incorrectly. Therefore, it is highly likely that if these improper payment figures were recalculated utilizing only denials that were found to be valid after appeal, the rate would be significantly lower.

In addition, there have been large, unexplained swings in the improper payment report figures for IRFs over the last several years. The findings have indicated the improper payment rate for IRFs have ranged from approximately 30 to 62% since 2016, without any explanation as to why IRFs

[17] The CERT reviews approximately 500 IRF claims per year, or approximately one tenth of one percent of all Medicare IRF claims.

[18] *See* https://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Appeals-Settlement-Initiatives/Inpatient-Rehabilitation-Facility-Appeals-Initiative.

would have changed their admission practices so drastically from year-to-year and with no significant regulatory change during this timeframe. In addition, the improper payment report has indicated anywhere from approximately 65 to 95% of improper payments were due to medical necessity (as opposed to documentation insufficiencies) during that same period, again without any explanation as to why IRF practices would vary so drastically from year-to-year.

Based on these and other factors, AMRPA believes the improper payment rate is more reflective of shortcomings of Medicare contractors and their understanding of the complex medical decision-making that is at the heart of IRF admission decisions. We therefore believe this data cannot be used to justify such a large-scale, burdensome, and operationally problematic demonstration that will affect patient access and care quality on a state-wide basis.

***

AMRPA is committed to continuing to work with CMS and the rest of the Administration on developing an efficient method of review for IRF claims that both ensures the integrity of the Medicare Trust Funds and ensures continued access to needed care for Medicare beneficiaries. To continue our dialogue, please contact Kate Beller, J.D., AMRPA Executive Vice President for Government Relations and Policy Development (kbeller@amrpa.org / 202-207-1132) or Jonathan Gold, AMRPA Regulatory Counsel & Director of Government Relations (jgold@amrpa.org / 202-860-1004) .

Sincerely,

Anthony Cuzzola
Chair, AMRPA Board of Directors
Vice President/Administrator, JFK Johnson Rehabilitation Institute

Appendix II

Reforms to Improve Medicare Audits of
Inpatient Rehabilitation Hospital and Unit (IRF) Claims

A recent series of audits and reports on IRF services have produced dubious conclusions and demonstrated a systemic inability of Medicare auditors to properly and consistently determine the medical necessity of these clinically complex services. IRF stakeholders are concerned about a widening gap between practitioners in the field and IRF auditors as to the proper interpretation of the medical appropriateness of IRF admissions. This disconnect is due in large part to a flawed and opaque audit process in which contractors second guess the treating rehabilitation physicians who are in the best position to make these complicated admission decisions in real time. In addition, numerous entities that audit IRF claims, which include Medicare Administrative Contractors (MACs), Supplemental Medical Review Contractors (SMRCs), Recovery Audit Contractors (RACs), the Comprehensive Error Rate Testing Contractor (CERT), and the Office of Inspector General (OIG), all interpret IRF coverage criteria differently, rendering good-faith efforts at compliance unpredictable and exceedingly resource-intensive.

We have developed a series of constructive reform proposals that would improve audit practices, bridge the understanding gap between auditors and practitioners, and produce decisions that more closely align with the real-word practice of rehabilitation medicine.

- **Create a Medical Rehabilitation Advisory Board:** CMS should create a standing Medical Rehabilitation Advisory Board to ensure that Medicare medical necessity standards and enforcement reflect the real-world practice of rehabilitation medicine. This Advisory Board would serve as a resource to Medicare policy makers on potential updates to IRF medical necessity criteria. The Advisory Board would also advise CMS and its auditors on the clinical interpretation of medical necessity for IRF services to ensure that reviewers and practitioners maintain parallel medical necessity expectations. The Board should be made up of actively practicing clinicians, including physicians with training and experience in rehabilitation, who are currently working in an IRF setting. Board members should be nominated by their peers.

- **Require Auditor Expertise:** Medicare regulations require the admitting rehabilitation physician in an IRF to have specialized training and experience in inpatient rehabilitation, and this same standard should apply to auditors. Unfortunately, contractors often use non-physicians, or physicians who do not meet Medicare's qualifications of a rehabilitation physician, to make medical necessity determinations. A lesser qualified clinician should not override the judgment of practicing rehabilitation physicians. CMS should require that only a physician who meets the Medicare requirements of a qualified rehabilitation physician, with current experience in IRF practice, review and approve all denials issued on the basis of medical necessity.

- **Make Auditor Instructions and Guidelines Available for Public Feedback and Discussion:** Currently, CMS does not disclose its specific instructions to contractors auditing IRF claims; and in turn, auditors do not disclose any internal guidelines they use to evaluate IRF claims. These instructions and guidelines should be available for review and feedback from practitioners in the field. This increased level of transparency would ensure that auditors and practitioners share the same expectations of medical necessity for IRF services. These reviews and feedback opportunities should be provided regularly so that audit practices keep pace with the evolution of modern medicine.

- **Require Specificity from Audit Contractors on Reasons for Denial:** CMS auditors, when denying claims, often cite one generalized aspect of the patient's medical record and then summarily assert, without analysis, that the patient did not meet one or more medical necessity requirements. CMS auditors should be required to explain how and why specific facts led to the conclusion that the patient did not meet the coverage criteria. This would help the provider to refine its admission and documentation practices to address deficiencies that are clearly identified and explained by the auditor and understood by the provider.

- **CMS Should also Standardize Error Rate Calculations**: Recent CMS efforts, such as the Targeted Probe and Educate (TPE) initiative, rely on the calculation of an error rate to determine whether further audits are necessary. However, the calculation of an error rate, as well as the acceptable rate to avoid future audits or pre-payment review, have never been clearly defined. Further, different CMS contractors apply different formulas and standards, which leads to unnecessary uncertainty and confusion among providers. Greater transparency and consistency in error rate calculation standards and procedures would help providers comply with Medicare requirements.

- **Require Contractors to Hold Forums with Practitioners in the Field and Provide Actionable Feedback:** Auditors should engage in an ongoing dialogue regarding the ever-evolving nature of rehabilitation medicine and IRF services. This dialogue will help to continually improve and refine audit practices to mirror the real-word practice of rehabilitation medicine. In addition, CMS should provide regular feedback from its auditors in a manner and form that providers can act upon in a timely manner. Such feedback should go beyond general, yearly updates. Rather, it should consist of detailed information, such as a breakdown of the reasons for claim denials on at least a quarterly basis. This type of feedback would allow providers to improve practices quickly and avoid unnecessary future improper payments.

- **Improve Auditor Communication with IRFs during Audits:** It is often difficult to decipher the full clinical picture of a patient from the perspective of a rehabilitation physician based solely on a written medical record. However, auditors rarely speak with IRFs or physicians about claims before making a determination. When an IRF or practitioner has an opportunity to explain its rationale on appeal, claim denials are overturned at a very high rate. Therefore, 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.