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October 8, 2021

William N. Parham, III
Director
Centers for Medicare & Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Paperwork Reduction Staff
Attention: CMS-10765
Room C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: Comments on the Notice of Collection of Information for a Review Choice Demonstration for Inpatient Rehabilitation Facility (IRF) Services (CMS–10765)

Dear Director Parham:

On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), which represents approximately 240 member hospitals and health systems, including nearly 70 inpatient rehabilitation facilities (IRF) and units across the commonwealth, we appreciate this opportunity to provide the Centers for Medicare & Medicaid Services (CMS) with the following comments on the Notice of Collection of Information for a Review Choice Demonstration for Inpatient Rehabilitation Facility Services (IRF RCD), published on September 8, 2021 (CMS–10765).

Pennsylvania's IRFs play a unique role in the commonwealth's care continuum. IRFs provide their patients with intense medical rehabilitation, therapy, and services that are delivered through a multi-disciplinary, team-based approach to patient care. In IRFs, unlike other less-intense post-acute care settings, rehabilitation physicians drive the patient admission process and lead, advise, and work collaboratively with the multi-disciplinary team of nurses, therapists, and other clinicians in caring for IRF patients.

The IRF RCD will subject all Medicare fee-for-service claims for IRF admissions in Pennsylvania, as well as Alabama, California, and Texas, to either pre-claim or post-payment review. While the program's stated purposes are to "improve methods for the identification, investigation, and prosecution of potential Medicare fraud," as we indicated in comments earlier this year about the agency's first paperwork reduction notice for an IRF RCD, we believe the approach contemplated in this notice likely will adversely impact access to necessary IRF care and create substantial paperwork and operational burden for clinical staff in IRFs already facing significant patient care and operational challenges associated with the COVID-19 pandemic.

HAP continues to hold the following concerns about the IRF RCD:

The IRF RCD will limit access to necessary care. Medicare's IRF coverage criteria are not general in nature; instead the criteria must be applied to each patient and their unique conditions and circumstances. Because of this specificity, IRF RCD reviews will likely result in claims denials that are inappropriate under IRF regulations. For example, IRF RCD reviews may misinterpret coverage requirements or utilize criteria that are not part of the IRF coverage regulations, such as impermissible diagnoses-based "rules of thumb" that deny IRF coverage based on a patient's diagnosis, or denials based on a reviewer's opinion that the patient could or should have been treated in another level of post-acute care. RCD review results will create additional confusion about which patients are appropriate for IRF care. Furthermore, if inappropriate denials are not easily cured or successfully appealed, IRFs may adjust their patient admission practices based upon erroneous RCD reviews, limiting access for other patients with similar diagnoses or clinical conditions. Risking patient access to IRF care is unacceptable. CMS must ensure that IRF RCD will not create "de facto" new rules.

As designed, the IRF RCD mandates that Medicare contractors second guess rehabilitation physicians' medical judgments. Many of our IRF members experience questionable "medical necessity" claim denials from CMS contractors and medical audit programs that result from misunderstandings or misapplications of Medicare's regulations governing IRF care and services. Often, these denials are made by non-physician practitioners who do not have experience or familiarity with IRFs and caring for IRF patients, unlike the rehabilitation physicians required by Medicare to determine whether to admit a patient based on applicable IRF admission and coverage criteria. Many of these denials are reversed on appeal before administrative law judges, especially when the rehabilitation physician is able to participate in the hearing and explain her or his decision to admit and treat the patient.

The IRF RCD will indiscriminately second guess 100 percent of the rehabilitation physicians who are charged with determining whether a Medicare patient should be admitted to an IRF. Second guess reviews will be conducted by nurse reviewers, not physicians who are experienced in caring for IRF patients and trained in medical rehabilitation. It is unlikely such reviewers will have the background, experience, or specialty knowledge in the field of complex medical rehabilitation that underlies the care provided in IRFs. Medicare contractors too often lack training and expertise with specialized rehabilitation care and Medicare's IRF coverage requirements. Any program that does not involve rehabilitation physician reviewers in chart and medical reviews will only result in harm to patients, excess burden, and large volumes of appeals. **Physician decisions to provide a patient with IRF care and services should not be denied without the review and approval of another experienced rehabilitation physician.**

The IRF RDC will create unwarranted administrative burden during a pandemic. Since the start of the COVID-19 pandemic, we have learned that IRF services are a critical component of the care continuum for some patients recovering from COVID. IRF care has been an important part of the commonwealth's public health emergency response. IRF RCD's across-the-board approach will impose undue administrative burden on IRFs that have no history of noncompliance and divert critical resources away from patient care. The IRF RCD program would significantly increase the volume of communication and administrative work that Pennsylvania's IRFs will need to incorporate into their existing workflows—workflows that are often already stressed by staffing challenges. Burdening every Pennsylvania IRF with the additional and onerous tasks associated with a 100 percent pre- or post-claim review process, including efforts and resource allocations put forth in contemplation of preparing for the implementation of such a process, is not appropriate or useful at a time when local, regional, and national health care providers and systems are still operating as the frontline in this ongoing pandemic.

Conclusion. For the above reasons, we reiterate our recommendation that CMS not implement the IRF RCD program as currently envisioned. Our IRF and acute care members support education around IRF coverage criteria compliance, but not at the risk of curbing patient access to critically important IRF services and unnecessarily burdening an important component of our COVID-19 response.

We thank you for the opportunity to comment on this notice for the IRF RCD paperwork reduction requirement information collection. If you have any questions concerning our comments, please feel free to contact me at (215) 575-3741.

Sincerely,

Jennifer Jordan
Vice President, Regulatory Advocacy