February 16, 2021

Liz Richter, Acting Administrator
Centers for Medicare and Medicaid Services
Office of Strategic Operations and Regulatory Affairs
Division of Regulations Development
Attention: CMS-10765
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via www.regulations.gov

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

Dear Acting Administrator Richter:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services' (CMS) proposed information collection on a Review Choice Demonstration for Inpatient Rehabilitation Facility (IRF) Services (CMS-10765).

CPR is a coalition of more than 50 national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities, and chronic conditions may regain and/or maintain the maximum level of health and independent function. We have serious concerns about the proposed demonstration and the consequences it would have for patient access to care in IRFs. This proposal would have a significant impact on the field of inpatient rehabilitation and could present additional barriers to appropriate care for patients in need of comprehensive, intensive, and interdisciplinary rehabilitation services provided in a hospital setting.

We urge CMS to withdraw this proposal to ensure that patients are not negatively affected. As a coalition of organizations whose members rely on this setting of care, we urge CMS to rethink this model and meet with stakeholders to find alternative, less onerous ways to achieve its primary objective—making sure the care provided in IRFs to Medicare beneficiaries is reasonable and necessary.

Proposed IRF Demonstration

CMS proposes to implement a "Review Choice Demonstration" (RCD) for IRFs in certain jurisdictions, during which facilities will be subject to 100% pre-claim or post-payment review

for their Medicare claims. While the demonstration would begin with all IRFs located in the state of Alabama, it would soon be expanded to several other states, eventually encompassing 17 states, three U.S. territories, and the District of Columbia. All IRFs in these Medicare Administrative Contractor (MAC) jurisdictions would be subject to 100% claims review, impacting hundreds of rehabilitation hospitals and, most importantly, thousands of Medicare patients. The Coalition to Preserve Rehabilitation believes this proposal would:

- Create a problematic "sentinel" or "gatekeeper" effect on IRF admissions, decreasing access to care both immediately and over time;
- Empower trained nurses to challenge and supersede the professional judgment and clinical decisions of physicians with specialized rehabilitation expertise;
- Dramatically increase provider burden, lessening the time available to be spent actually serving patients' needs;
- Potentially disrupt courses of IRF treatment in the case of pre-claim denials; and
- Divert Medicare beneficiaries away from the IRF setting to which they are entitled to lesser intense settings of post-acute care, resulting in the risk of lesser outcomes.

The Proposal Will Limit Patient Access to IRF Care

The Coalition to Preserve Rehabilitation is concerned that the proposed demonstration will further limit access to inpatient rehabilitation care for patients in need of the high level of medical management and rehabilitation therapy provided in IRFs. We have long expressed apprehension about the growing barriers to access for patients in need of post-acute care, whether due to the overuse of prior authorization and other utilization management techniques in the Medicare Advantage program, the harmful incentives in the Patient-Driven Payment Model and the Patient-Driven Groupings Model implemented in the Skilled Nursing Facility and Home Health payment systems, respectively, and numerous restrictive regulations and documentation requirements within the IRF payment system. In addition, we note that CMS has implemented a version of a similar review demonstration in the home health payment system, which has been extremely challenging for patients and providers and has undergone multiple pauses and revisions, calling into question whether it is appropriate to expand this model to other practice settings. The sum total of all of these policies translates into less patient access to rehabilitation services across the Medicare post-acute care continuum.

As noted above, the proposed demonstration would subject IRFs in the qualifying jurisdictions to 100% review of their Medicare claims. Given the historical trends relating to IRF denials, including denials based on technical documentation deficiencies, we expect that this demonstration would significantly increase the percentage of denied IRF cases, even when the rehabilitation physician has made a considered medical judgment that a given patient is in need of this level of care.

In the case of pre-claim review, a denial would place the rehabilitation physician in the position of either discontinuing the course of treatment for a patient that they believe requires IRF-level rehabilitation or continuing to treat the patient and placing the IRF at risk of nonpayment and being subjected to the administrative appeals process to overturn the denied claim, which can

take years (despite a statutory requirement for a 90-day decision at the Administrative Law Judge level).

We are concerned that patients whose conditions may be atypical of the need for IRF care but are determined to nonetheless qualify for IRF admission will begin to be turned away for fear of being denied under the RCD. This may lead to large swaths of patient diagnoses or other characteristics leading to presumptive denials under this demonstration. We are particularly concerned that such categorical decisions will end up being tantamount to denials based on treatment norms or "rules of thumb." CPR has a long history of opposing IRF denials for these reasons, whether through regulation (such as the three-hour rule, which we believe encourages rule of thumb denials) or through demonstrations such as the proposed RCD.

As the agency is aware, *Hooper v. Sullivan*[1] requires an individual assessment of what services are actually required by each patient and makes it clear that a hard and fast numerical rule can *only* be used to screen for coverage, not to grant or deny Medicare coverage. The *Hooper* case law clearly prohibits the use of rules of thumb to deny IRF admission, which raises serious questions about the potential impact of this demonstration. We are also concerned that empowering the MACs with this level of authority over IRF claims may encourage these Medicare contractors to utilize these rules of thumb, especially when the power to deny claims is passed off to non-physician practitioners who are being put in the position of overruling treating rehabilitation physicians.

The Proposal Will Empower MACs to Bypass Physician-Led Care

Under the proposed RCD, CMS states that the documentation submitted by IRFs for pre-claim or post-payment review will be reviewed by "trained nurse reviewers." We note that CMS has promulgated extensive regulatory criteria defining the requirement for IRF care to be led by a qualified rehabilitation physician, which is integral to the unique, intensive level of rehabilitation provided in IRFs. Nursing, and rehabilitation nursing in particular, is a critical function in IRFs and other settings of post-acute care, and rehabilitation nurses play an integral role on the rehabilitation team in treating and managing patients with complex injuries, illnesses, disabilities, and chronic conditions. However, trained nurses should not be empowered to overturn physician judgment, and we question the decision for the demonstration reviews to be conducted by nurses who would not be allowed to make admission decisions in an IRF. CPR is a strong proponent of physician-led care in IRFs, and decisions regarding which patients are appropriate for admission to an inpatient rehabilitation hospital should be left to qualified treating rehabilitation physicians in consultation with the rehabilitation team.

Implementing this demonstration as proposed would essentially empower the MACs, private companies intended to assist in administering the Medicare program, to supersede physician judgment and determine a Medicare patient's medical necessity without directly evaluating the patient beyond a record review of the patient files. Providers who disagree with denials during the pre-claim or post-payment review would be able to submit claims anyway and expect to undergo the typical appeals process if their claims are denied. However, the Medicare appeals

[1] *Hooper v. Sullivan*, No. H-80-99 (PCD), 1989 WL 107497 (D. Conn. July 20, 1989).

process has long been broken, and since CMS does not propose any expedited or separate appeals process to accommodate timely appeals of the denials under the RCD, initial denials will essentially function as the final word on IRF claims.

The proposed RCD will allow MACs to essentially dictate IRF admissions over the protestations of treating physicians who are simply trying to ensure their patients receive the level of rehabilitation care they need and deserve. This will exacerbate existing barriers to patient access. The medical necessity decisions regarding the appropriate setting for complex patients with serious illnesses, injuries, disabilities, or chronic conditions should be made between the patient and qualified rehabilitation physician and the rehabilitation team.

The Proposal Will Increase Provider Burden, Limiting Time Spent with Patients

CPR has long expressed our concerns with the extensive and sometimes duplicative documentation requirements faced by IRF providers, along with other burdensome requirements within the IRF system. We have noted that these contribute to high rates of physician burnout and increased technical documentation denials of IRF claims, the latter of which further strain an already over-taxed appeals process without improving patient care. CPR is worried that the proposed demonstration will significantly increase provider burden in IRFs, which will take providers away from treating patients in need of intensive rehabilitation and medical management.

While CMS estimates that physicians will not spend time preparing the documentation for submission during the demonstration, we seriously question this assumption. Physician involvement is necessary when fighting for the rights of patients that are inappropriately denied admission to an IRF. When admitting physicians are overruled by payers, they tend to be motivated to demonstrate the propriety of their clinical decisions and assuming they will not engage in a defense of systematic IRF denials under the demonstration is misguided. Furthermore, physicians will certainly be burdened by spending significant time and resources testifying before Administrative Law Judges (ALJs) once these claims arrive at the ALJ level of review, if and when claims are inappropriately denied during the demonstration. These increased burdens will trickle down to significantly impact patient care, taking physicians and other IRF providers away from directly treating patients and increasing burnout and strain on providers.

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Access to rehabilitative care in the most appropriate setting for individual patients is essential for the health, function, and a return to community living for people with disabilities and others in need of medical rehabilitation and post-acute care. **In order to ensure that beneficiaries are able to access the care they need without undue barriers, we urge CMS to withdraw the proposed IRF Review Choice Demonstration and work with stakeholders to achieve CMS's goals without unfairly burdening or harming patients.**

We greatly appreciate your attention to our concerns involving this proposed demonstration. Should you have further questions regarding these comments, please contact Peter Thomas and

Joe Nahra, coordinators for CPR, by e-mail at Peter.Thomas@PowersLaw.com and Joseph.Nahra@PowersLaw.com, or by calling 202-466-6550.

Sincerely,

The Undersigned Members of the Coalition to Preserve Rehabilitation

ACCSES
American Academy of Physical Medicine and Rehabilitation
American Association of People with Disabilities
American Congress of Rehabilitation Medicine
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Occupational Therapy Association
American Physical Therapy Association
American Speech-Language-Hearing Association
American Spinal Injury Association
American Therapeutic Recreation Association
Association of Academic Physiatrists
Association of Rehabilitation Nurses
Brain Injury Association of America*
Center for Medicare Advocacy*
Christopher & Dana Reeve Foundation*
Clinician Task Force
Disability Rights Education and Defense Fund
Falling Forward Foundation*
National Association for the Advancement of Orthotics and Prosthetics
National Association of Social Workers (NASW)
National Council on Independent Living
National Multiple Sclerosis Society*
Rehabilitation Engineering and Assistive Technology Society of North America
Spina Bifida Association
Uniform Data System for Medical Rehabilitation
United Cerebral Palsy
United Spinal Association*

**** CPR Steering Committee Member***