Inpatient Rehabilitation Facility Proposed Review Choice Demonstration

Member Comment Letter Template

Instructions

**Comments due to CMS October 8, 2021**

Comments can be submitted [here](https://www.reginfo.gov/public/do/PRA/icrPublicCommentRequest?ref_nbr=202109-0938-007).

Document ID: CMS-10765

For reference, AAPM&R’s past letter on this issue is linked [here](https://www.aapmr.org/docs/default-source/advocacy/reg_2-16-21_final-aapmr-comments-on-the-proposed-irf-rcd.pdf?sfvrsn=6a80207c_10). AAPM&R’s news story on the issue is linked [here](https://www.aapmr.org/members-publications/member-news/member-news-details/2021/02/17/aapm-r-submits-comments-to-cms-opposing-review-choice-demonstration-for-irf-services).

Please use the below template to submit your own, individualized letter to the Centers of Medicare and Medicaid Services (CMS) opposing the proposed Inpatient Rehabilitation Facility (IRF) Review Choice Demonstration (RCD). CMS proposes to implement a “Review Choice Demonstration” for IRFs, which would subject selected IRFs to 100% pre-claim or post-claim review of their Medicare claims. While this demonstration would begin with all IRFs in Alabama, CMS proposes to expand the RCD to all providers in four Medicare Administrative Contract (MAC) jurisdictions, covering 17 states, three U.S. territories, and the District of Columbia.

AAPM&R believes that this RCD would add significant burden to physiatrists working in IRFs and fundamentally alter the patient population by allowing MACs overrule admitting physician decisions and curtail access to IRFs for patients under Medicare coverage if the MAC determines the IRF care is not appropriate for the patient.

Please submit comments to CMS opposing the demonstration and explaining how it would create further burnout and barriers to care. The suggestions in [brackets] below are there to guide your comments, but please feel free to make these your own, as they are coming from you as an individual.

Template

October 8, 2021

Chiquita Brooks-LaSure, Administrator Shalanda Young, Acting Director

Centers for Medicare and Medicaid Services Office of Management and Budget

Attention: CMS-10765 725 17th Street NW

7500 Security Boulevard Washington, DC 20500

Baltimore, MD 21244-1850

*Submitted electronically to www.regulations.gov*

**Re: Proposed Review Choice Demonstration (RCD) for Inpatient Rehabilitation Facility**

**Services (CMS-10765)**

Dear Administrator Brooks-LaSure and Acting Director Young:

I am writing to strongly oppose the proposed Review Choice Demonstration (RCD) for Inpatient Rehabilitation Facilities (IRFs).

Physiatrists have a key role in inpatient hospitals and units in admitting appropriate patients to this level of intensive, coordinated, multidisciplinary rehabilitative care. A 100% pre-claim or post-payment review of all Medicare beneficiary admissions by a third party, Medicare Audit Contractors, will fundamentally transform the kinds of patients who have access to IRF care, taking admission decisions out of the hands of trained rehabilitation physicians and placing them in the hands of non-physicians who perform nothing more than an after-the-fact paper review of the record. This will fundamentally alter the patients who have access to IRF care.

* [Briefly describe how this will undermine your decision making. Will it take excess time? Will it make your job harder?]
* [As a physiatrist, how do you feel hearing that CMS contractors are seeking to second-guess your medical decision-making?]
* [What skills and knowledge do reviewers need to have to adequately determine if a patient should be admitted to an IRF?]
* [What does your process look like when evaluating patients for IRF admission – how detailed is your examination and how discerning are you during the pre-admission period? What percentage of IRF referrals do you already reject because they do not meet coverage criteria?]

This demonstration will introduce significant access issues for patients in need, despite CMS’ claims to the contrary, exacerbating pre-existing barriers to access for IRF patients.

* [A point about Medicare beneficiaries being patients in need of complex care and close monitoring, and in particular how IRF patients have more complex needs than patients appropriate for other PAC settings.]
* As MACs deny more and more claims due to medical necessity under the demonstration, it will necessarily have an impact on IRF practices. Providers & facilities cannot keep admitting patients that are getting categorically denied by MACs indefinitely, even when the medical necessity is clear – it will be impossible to defend all the claims throughout the lengthy appeals process.

This demonstration will create even more provider burden than already exists, as physicians are dangerously burnt out.

* We appreciate that in recent years, CMS has recognized the importance of reducing provider burden across the Medicare program and implore CMS to maintain that effort now.
* The proposed demonstration would add a significant burden to my work because physicians and other clinical members of the rehab team will be required to prepare the documentation for the pre-claim or post-payment reviews- a shocking 100% of claims. CMS states that only clerical staff will be involved in this documentation – this will clearly not be the case.
* [Describe how much time does it takes you to review a patient file and defend the medical necessity of each claim at issue, especially when involved in appeals and considering that **all** claims will now have to go through this process.]
* [Describe how often you as a physician are required to be involved in documentation and how this is not “just” an administrative staff responsibility.]
* [Describe how you feel about paperwork taking time away from patients.]

The qualifications of the reviewers CMS is offering are inadequate and will result in poorer quality care as the MAC decisions get translated into IRF admissions practices.

* CMS offers that “trained nurse reviewers” will determine if a patient requires IRF services. CMS agreed in its most recent version of the RCD that physicians would be involved, but only a rehabilitation physician that meets the regulatory requirements for admitting patients should be permitted to deny claims at the MAC. IRF coverage requirements require a “rehabilitation physician” to direct IRF care and determine admission.
* [Why should a nurse reviewer who has never met the patient have the ability to override the admitting physician’s determination?]
* [Detail how extensive your training and experience in rehabilitation is as a physiatrist and why nurse auditors who do not ever see the patient in question should not be able to override your clinical decisions.]
* [How will this interrupt and impact quality of care for patients?]
* [How might it disrupt your work?]

An alternative option to this proposal to ensure Medicare dollars appropriately and efficiently spent in IRFs is to require tighter regulatory standards for the role of rehabilitation physician.

* [Describe the complex patients who benefit from IRF care]
* [How are physiatrists particularly required to work in IRFs?]
* [Have you personally experienced having a non-physiatrist in this position and had repercussions for your patients? Or has this increased your burden?]

If CMS insists on moving forward with this demonstration in the face of widespread opposition, I insist that this demonstration be delayed until after the COVID-19 public health emergency.

* [What is happening in your IRF? Is it overwhelmed with patients because the acute care hospital is full? Are patients struggling to access rehabilitation because the surges are disrupting patient flow through the continuum?]
* Physicians cannot be expected to spend critical hours compiling documentation and convincing Medicare contractors of the appropriateness of their IRF admission decisions at a time when all efforts are needed on the front lines of the pandemic.

Thank you for your consideration of my comments.

[Your name]

[Your position]