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Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
Washington, DC

Shalanda D. Young
Acting Director
Office of Management and Budget
Washington, DC

Submitted via regulations.gov

Re: CMS-10765, "Review Choice Demonstration for Inpatient Rehabilitation Facility (IRF) Services"

Dear Administrator Chiquita Brooks-LaSure and Acting Director Young,

On behalf of Uniform Data System for Medical Rehabilitation (UDSMR) and the more than nine hundred inpatient rehabilitation facilities we provide services to, we welcome the opportunity to present our comments on CMS-10765, "Review Choice Demonstration for Inpatient Rehabilitation Facility (IRF) Services" (RCD), which was updated on September 8, 2021, in the *Federal Register*. With over thirty years of experience, UDSMR provides coding, clinical, compliance, quality improvement, outcomes management, and technical support services to IRFs and other postacute care (PAC) providers. UDSMR appreciates the opportunity to provide ongoing feedback to CMS and hopes to work with CMS to create solutions that meet the needs of IRF providers and patients.

Following the initial publication of the RCD on December 15, 2020, UDSMR shared multiple concerns in a comment letter submitted on January 28, 2021. These concerns included pervasive issues with existing and prior IRF claim reviews, as well as the high rate of denials that are overturned on appeal. This latter issue makes IRF payment error rates, which are CMS's stated justification for the demonstration, highly likely to be overstated. Our letter provided specific examples of common, pervasive issues with IRF reviews, including the following:

- Nonspecific findings for not meeting "reasonable and necessary" admission criteria
- Denials that were not based on IRF regulations
- Conflicting findings
- The establishment of inconsistent and arbitrary thresholds for medical and functional acuity

Additionally, the 100% pre-claim or postpayment review is an extraordinarily burdensome proposal, particularly during the current public health emergency, and it will divert operational focus and resources away from patient and community needs.

In light of the significant regulatory changes in the FY 2021 IRF final rule and the subsequent revisions in 42 *CFR* § 412.622 and the *Medicare Benefit Policy Manual* (*MBPM*) § 110, we reiterate our request that CMS conduct extensive education universally for contractors and providers alike regarding IRF policies and regulations. Additionally, the Supreme Court decision in Azar v. Allina has significant implications for what may or may not constitute an overpayment in an IRF case, but contractors continue to assert that *CFR* and *MBPM* elements carry the same weight in determining payment decisions. CMS responded to this concern by stating that "[r]eviewers will follow the same review guidelines as they currently do, as no new documentation will be required under the demonstration" and that "CMS has published numerous educational materials to inform IRFs and Medicare beneficiaries of the policies and documentation requirements for IRF services," but the review guidelines are out of date, as are all the published educational materials. None of these resources have been updated to reflect the FY 2021 IRF final rule and the subsequent revisions in 42 *CFR* § 412.622 and *MBPM* § 110.

In its response to comments, CMS stated that it "will ensure there is continued oversight of all MAC activities under this demonstration. The MAC reviewers will undergo training to ensure consistency prior to beginning the reviews. Both the MAC and CMS will monitor the reviewers' accuracy throughout the demonstration and CMS staff will conduct reviews on a selection of requests/claims to ensure the MAC decisions are accurate and consistent across reviewers." Given the current and pervasive issues with IRF reviews and the recent regulatory changes, this oversight would need to be extensive. As such, CMS may be underestimating the financial burden of this undertaking. Additionally, CMS needs to include appeal contractor reviewers in reeducation efforts related to IRF regulations, including FY 2021 changes, and the applicability of Azar v. Allina to IRF regulations and guidance. Extensive revision and retraining are required, but CMS also should evaluate the effectiveness of its training through standard, established review avenues involving a sample of IRF claims versus a 100% review demonstration.

We appreciate that CMS acknowledged our concern that "trained nurse reviewers" would be the ones who would "use the documentation to determine if the beneficiary qualifies for IRF services and if they need the level of care requested." However, modifying this by specifying that the reviews will be conducted by "trained registered nurses, therapists, or physician reviewers" does not address the core concern: that non-rehabilitation physicians and other professionals should not be allowed to overrule a rehabilitation physician's admission decision based on their own subjective and arbitrary criteria in the absence of evidence that the decision violated a reasonable standard of care.

CMS did not address the fact that many inpatient rehabilitation units use clinical staff to complete clerical tasks, such as IRF-PAI completion and transmission, in addition to their clinical duties and that they also use paper or hybrid (paper and electronic) medical records due to the unique documentation requirements that exist for IRFs. Adding clerical staff is not feasible in some units, and the process of collecting, scanning, compiling, submitting, and tracking medical record submissions, particularly paper or hybrid records, will often require *clinical* staff to spend more than the projected thirty minutes to complete these tasks. In addition, clinical staff are involved in appeals that will inevitably result from this demonstration. Therefore, we continue to be concerned that the burden on IRFs has been underestimated and that it may result in negative consequences that affect patient care resources.

Although UDSMR appreciates that CMS corrected information in the original RCD support documents that was inconsistent with changes made in the FY 2021 IRF final rule, the

individualized plan of care section of the new form and instruction document published with the RCD update on September 8, 2021, contained the following information:

> A non-physician practitioner can fulfill the IRF services and documentation requirements currently required to be performed by the rehabilitation physician in 42 *CFR* § 412.622(a)(3), (4), and (5). Therefore, of a non-physician practitioner with the current definition of a rehabilitation physician in that we expect the IRF to determine if the non-physician practitioner has specialized training and experience in inpatient rehabilitation and may perform any of the duties that are required to be performed by a rehabilitation physician, provided that the duties are within the non-physician practitioner's scope of practice under applicable state law.

This statement is inconsistent with 42 *CFR* § 412.622, the *MBPM* § 110, and all prior CMS clarification regarding the roll of a non-physician practitioner with regard to IRF regulations and required documentation.

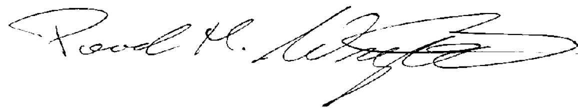
We recommend that CMS suspend implementation of the proposed Review Choice Demonstration for IRF Services until the aforementioned extensive education of review contractors, appeal contractors, and providers can be conducted and properly vetted through standard, existing review processes.

We appreciate both the opportunity to comment on this proposed demonstration and CMS's careful consideration of the concerns and issues raised in this letter. If you have any questions about these comments or require additional information, please contact us at 716-817-7800.

Sincerely,

Brigid Greenberg, PT, MHS
Manager of Postdischarge Services and Appeals

Troy Hillman
Vice President of Government Affairs



Pawel Wieczorek
Chief Executive Officer