August 12, 2019

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Delivered Electronically

Re: Request for Information; Reducing Administrative Burden To Put Patients Over Paperwork [CMS-6082-NC], 84 Fed. Reg. 27070 (June 11, 2019)

Dear Administrator Verma:

The American Academy of Physical Medicine and Rehabilitation (AAPM&R) and the American Medical Rehabilitation Providers Association (AMRPA) write to you with proposals to address some of the unnecessary administrative burdens faced by physicians in inpatient rehabilitation hospitals and units. AMRPA is a national trade association representing more than 650 freestanding inpatient rehabilitation hospitals and rehabilitation units of general hospitals (collectively referred to by Medicare as IRFs). AAPM&R is the national medical specialty organization representing more than 9,000 physicians who are specialists in physical medicine and rehabilitation (PM&R). PM&R physicians, also known as physiatrists, are experts in designing comprehensive, patient-centered treatment plans and treat a wide variety of medical conditions, injuries, illnesses, and disabilities. Physiatrists practice in many different settings of post-acute care (PAC) but have a special relationship with IRFs, serving as medical directors and attending physicians in this post-acute care setting.

Patients treated in IRFs have experienced a serious injury or illness and require intensive therapy coupled with close medical management in order to regain functional loss. IRFs provide hospital-level care, which is significantly different in intensity, capacity, and outcomes from care provided in non-hospital PAC settings. Per CMS regulation, the clinician charged with overseeing care in an IRF is a rehabilitation physician, which is usually a physiatrist. Despite a deep commitment to their patients, far too much of a rehabilitation physician’s time in an IRF is

1 See 42 C.F.R. § 412.622 (The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines and an intensive rehabilitation therapy program of at least three hours of therapy per day at least 5 days per week. In addition, the patient must require physician supervision by a rehabilitation physician consisting of face-to-face visits with the patient at least 3 days per week throughout the patient’s stay in the IRF).
2 See id. § 412.622(a)(3)(iv) (requiring the rehabilitation physician have specialized training in inpatient rehabilitation) and id. § 412.29(g) (requiring IRFs have a Director of Rehabilitation who is a physician with at least 2 years of training or experience in the medical-management of inpatients requiring rehabilitation services).
spent meeting arbitrary administrative burdens that often bear little clinical relevance to the patient’s treatment. In fact, data related to physician burnout clearly demonstrates the toll that compliance requirements and other burdens place on physiatrists.3

As you noted so succinctly in recent remarks to fellow health care professionals, “[e]very hour saved from reducing needless administrative burden is an hour more that our healthcare system can spend improving Americans’ health outcomes, and every needless requirement we eliminate saves patients and taxpayers money.”4 AAPM&R and AMRPA, as the national organizations representing both physiatrists and the hospitals in which they deliver care, strongly share this vision. To that end, we hope you will advance our proposals to enable rehabilitation physicians to spend more time improving outcomes and saving patients rather than diverting resources to duplicative or unnecessary administrative tasks.

The proposals we put forward are divided between unnecessary burdens placed on physicians in the traditional Fee-For-Service Medicare (FFS) program and the troublesome prior authorization process put in place by Medicare Advantage (MA) plans. AAPM&R and AMRPA have submitted some of these proposals to CMS in past comment letters; however, we would like to jointly resubmit them for your consideration as we believe they could be implemented without significant changes to Medicare regulations, while providing meaningful benefit to patients, physicians and the Medicare program.

I. Proposals to Lessen Burden in the Medicare Fee-For-Service Program

Rehabilitation physicians are perpetually stymied by the voluminous and burdensome CMS documentation requirements for IRF coverage under Medicare. These requirements lay out a step by step process for physicians to follow to have a patient qualify for coverage of IRF treatment. The coverage rules, which impose a framework the physician must follow through the entire patient’s stay, arguably dictate more about how the rehabilitation physicians should practice medicine than exists in any other setting of care covered by Medicare. In addition, the regulations require redundant and sometimes clinically irrelevant information to be contained in the patient’s medical record. Examples of the numerous and sometimes conflicting compliance requirements for IRFs include:

- The physician must review and concur with a comprehensive pre-admission screening (PAS) that must occur no earlier than 48 hours of admission to the IRF.
- The physician must then conduct a post-admission physician evaluation (PAPE) no later than 24 hours after the patient is admitted to an IRF and compare the findings to the PAS.
- No later than 4 days after the patient’s admission, the rehabilitation physician must have developed an individualized overall plan of care (IPOC) for the patient and have it placed in the medical record.

3 Medscape National Physician Burnout, Depression & Suicide Report 2019, Medscape, January 16, 2019. Retrieved from: https://www.medscape.com/slideshow/2019-lifestyle-burnout-depression-6011056?src=WNL_physrep_190116_burnout2019&uac=306605AJ&impID=1861588&faf=1#3 (finding physiatrists ranked as the third most burnt out specialty among the 50 ranked specialties, with 52% of reporting physiatrists feeling burnt out. The average percentage of burnout for all physician specialties was 44%).

• The physician must conduct a minimum number of visits per week and make specific determinations.\(^5\)
• The physician faces specific requirements with respect to the type and frequency of weekly clinical team meetings that must be convened.\(^6\)

These requirements stand in stark contrast to requirements for admission to an acute-care hospital, which just requires a history and physical. While we recognize that these rules are intended to ensure that appropriate patients qualify for IRF care and that IRF patients receive the intensive services they need, we believe the overly prescriptive nature of these requirements, and the time limits in which they occur, results in clinicians jumping through hoops to meet CMS requirements rather than focusing their efforts on the individualized needs of each patient. We strongly believe that rehabilitation physicians, in accordance with their expertise and training, as well the policies and procedures of their hospital, should have greater flexibility to provide timely and intensive hands-on care for IRF patients. We believe that offering physicians regulatory relief in this area will result in more patient-centered care, in line with the goals of this Administration.

We are equally concerned with the fact that Medicare contractors deny payment for entire IRF visits for small, technical violations, such as missing one of the numerous documentation deadlines by a few hours – even if the patient’s chart otherwise clearly demonstrates the need for IRF care. This is particularly onerous now that electronic medical records time stamp every amendment to the medical file. The proposals below would keep much of CMS’ current framework for IRF coverage intact but provide relief from redundant and unnecessary requirements.

A. CMS Should Ensure Physicians Are Not Required to Include Redundant Documentation
The PAS, PAPE, and IPOC—taken together—are unnecessarily burdensome because they require physicians to document the exact same information in multiple places at slightly different points in time. Unfortunately, to date CMS has not clarified its regulations to allow for a piece of information found elsewhere in the medical record to satisfy requirements under another document element. The result is that claims are routinely denied for missing information that is contained elsewhere in the patient’s chart. Some examples include:

• Both the PAS and the PAPE require an IRF to document the patient’s level of function prior to the onset of the current illness. Under no circumstances will the preadmission level of function have changed between the documentation for the PAS and PAPE, but contractors deny claims unless the same information is found in both elements.
• The PAPE requires an IRF to document the patient’s current functional status, even when it is the same as documented in the PAS. While it is reasonable that the PAPE

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\(^5\) The regulated minimum is often confusing to our members, who typically see patients far more than the minimum three visits per week by their own judgment. It may be helpful to emphasize that three visits per week is a minimum, and physicians should use their discretion as to how many physician visits individual patients need.

\(^6\) 42 C.F.R. § 412.622.
include notation that there has not been any change in function, if there is no change, providing documentation to this effect is entirely redundant of the PAS.

- The IPOC requires a rehabilitation physician to support the patient’s IRF plan of care by repeating a litany of informational items contained in other documentation elements included in the PAS and PAPE.

The time and effort required by rehabilitation physicians to document the same elements multiple times and in multiple places is a drain on physician resources. We recommend that CMS simplify its regulations to ensure physicians are not required to re-document the same element multiple times and provide physicians leeway to document their cases in the way they deem most medically appropriate. This could include an affirmative statement that documentation found in one location in the medical record satisfies that element for all other documentation requirements. Another approach would permit a “totality of the circumstances” test to determine whether the documentation, taken as a whole, sufficiently justifies medical necessity. Under this standard, no one piece of documentation would be determinative of an appropriate claim. Rather, the contractor would need to evaluate the claim as a whole to determine medical necessity. Finally, until such regulatory approaches are implemented, CMS could instruct contractors through sub regulatory means to deem information found elsewhere in the medical record to satisfy the requirements of any documentation requirement for IRF services.

B. Provide Additional Flexibility for Arbitrary Time Requirements, Especially on Weekends and Holidays

The rehabilitation physician treating the patient is in the best position to evaluate the patient and put in to motion their plan of care. However, these specialized physicians are forced to mold their approach to fit CMS’ tight and subjective timeframes. There are two major unnecessary timeline burdens placed on rehabilitation physicians that could be alleviated with small changes to the CMS regulations: (1) establishing time-related requirements in days, rather than hours, to avoid arbitrary cut-off periods during a workday, and (2) offering greater flexibility for documentation timeframes during weekends and holidays.

First, CMS uses a 48- and 24-hour standard for the PAS and PAPE, respectively. If CMS were to rephrase these regulations as a “day” standard, it would go a long way to alleviate pressure on physicians to correctly time their documentation submissions. To illustrate, currently a physician must be aware of the time a patient was admitted to an IRF in order to ensure the PAPE is completed no later than that exact time the next day. If CMS’ deadline for the PAPE were instead phrased as “midnight the next calendar day,” rehabilitation physicians would not be caught in the position of having to interrupt direct patient care in order to fill out and submit documentation by an onerous deadline having nothing to do with patient quality or outcomes. CMS could similarly implement this change for the deadlines applicable to the PAS and IPOCs, so providers are not required to fixate on exact times, and instead have flexibility within the next calendar day(s) to complete the requirements in a way that does not interfere with patient care, while maintaining the spirit of the regulation and ensuring patients are seen and tended to in a timely fashion.

Second, we ask CMS to allow flexibility for deadlines on weekends and holidays. As an example, if a patient is admitted to an IRF late on a Friday, the physician must complete the
PAPE by late on a Saturday. Often, the clinical difference between the PAPE taking place on a Monday morning instead of a Saturday evening is negligible. **CMS could add a clause to its regulations to require that the documentation be completed within 24 hours, or by midnight the next business day, whichever is later.** This would allow rehabilitation physicians to focus on the most pressing needs of patients and complete the PAPE during the next business day, if clinically appropriate. As another example, if the PAS took place on Friday, providers need to ensure that the patient is officially admitted on Monday no later than the time the PAS took place on Friday, or otherwise run afoul of the regulation. Adding an end-of-the-day standard would similarly provide appropriate flexibility for clinicians so they are free to finish admitting the patient by the end of the day Monday, rather than by a seemingly arbitrary time deadline.

C. **Eliminate Denials for *De Minimis* Omissions in the Medical Record When Medical Necessity is Clearly Demonstrated**

As previously mentioned, rehabilitation physicians and IRFs are put in the precarious position of having payment for an entire IRF stay denied due to relatively minor missing or deficient documentation, such as a PAPE being conducted an hour late or a missing signature on team meeting notes. This is the case regardless of whether the totality of the medical record clearly indicates the need for IRF services, and that the patient received the appropriate level of services. Consistent with CMS’ Patients Over Paperwork initiative, CMS should eliminate this draconian standard and take a more pragmatic approach to evaluating IRF claims.

CMS could take several approaches to eliminating these technical denials and allow rehabilitation physicians to focus more on their patients and less on paperwork. The first approach would be to amend the current IRF regulations with a statement that claims will not be denied due to a minor technical deficiency, and a determination of medical necessity for IRF services shall be based on the totality of the medical record. Alternatively, CMS could instruct contractors to ignore *de minimis* or non-material omissions or deficiencies in the medical record when the totality of the record indicates medical necessity requirements were satisfied.

We appreciate CMS’ efforts to ensure physicians are not diverted from patient care by duplicative or unnecessary recordkeeping and reporting requirements. To this end, we ask CMS to allow rehabilitation physicians practicing in IRFs to focus on delivering needed care to beneficiaries and eliminate technical denials when medical necessity is otherwise demonstrated.

**II. Proposals to Reduce Burden Resulting from Medicare Advantage Practices**

In addition to the unnecessary burdens placed on rehabilitation physicians by the Medicare FFS program, IRFs and rehabilitation physicians find that Medicare Advantage (MA) plans are placing an untenable burden on physicians through their prior authorization process. According to membership reports, this is due to the fact that an inordinate number of prior authorization
requests for IRF services are initially denied.\textsuperscript{7} These denials set off an appeals process that is
time consuming and takes physicians away from delivering patient care, thereby delaying access
to needed care for beneficiaries.

Even the most expeditious MA plans take one to three business days to respond to a prior
authorization request for IRF admission. This simply is not in the best interest of patients. In
addition, if a patient becomes ready for discharge late in a week or on a weekend, the approval to
transfer the patient from an acute care hospital to an IRF will be further delayed while MA plans
are closed for the weekend. Once an initial denial is issued on the medical record, a physician
can then engage in what is known as a peer-to-peer discussion with the MA plan’s clinical
personnel to attempt to justify the IRF admission. However, despite hospitals having 24/7
operations, MA plans provide limited timeframes for these discussions. This forces both acute
care hospitalist physicians, who are caring for very acute patients, or the rehabilitation
physicians, to rearrange their other duties to spend time justifying their judgement to a clinician
who has not ever seen the patient and is often not trained in rehabilitation medicine.

During this process, the acute-care hospital has the precarious and potentially untenable choice
of either continuing to hold on to a patient who may have been ready for discharge days prior, or
discharging the patient to another, perhaps less appropriate, PAC setting. This is frustrating to
patients, their families, and physicians who attempt to use their best medical judgment to place a
vulnerable patient in the best site of care, only to have plans supersede their decision and
ultimately delay or deny access to needed IRF care.

To address this issue, we propose that CMS bar MA plans from using a prior authorization
program for IRF services. As explained in the prior section, CMS regulations already dictate a
thorough screening process for IRF services. CMS should require MA plans to align their
requirements with the fee-for-service program and review claims on a post-service basis. In
addition to lessening physician burden, this would also ensure that MA beneficiaries are not
inappropriately denied access to services to which they are legally entitled.\textsuperscript{8} At the very least, we
ask CMS to implement the following guardrails to both protect vulnerable rehabilitation patients
and lessen burden on physicians.

1) Require a Physician with Specialized Training and Experience in Rehabilitation to
Make Prior Authorization Determinations
Rehabilitation physicians report they spend an outsized amount of their time on the phone
with MA plans justifying admission decisions. Medicare regulations require IRFs to
utilize a physician with specialized training and experience in rehabilitation.\textsuperscript{9} Despite this
requirement, MA plans utilize clinicians with lesser or no training in rehabilitation
medicine to overrule rehabilitation physician admission decisions and deny prior
authorization requests. In the appeal phase, rehabilitation physicians find that the title of

\textsuperscript{7} Medicare Payment Advisory Commission, Report to The Congress: Medicare Payment Policy 298 (Mar. 2017).
(Finding that MA beneficiaries are admitted to IRH/Us at a rate nearly three times less than traditional Medicare beneficiaries).
\textsuperscript{8} Medicare Managed Care Manual Chapter 4. Revision 121, Issued: 04-22-16 (“While an MA plan may offer
additional coverage as a supplemental benefit, it may not limit the original Medicare coverage. MA plans must
provide their enrollees with all basic benefits covered under original Medicare.”).
\textsuperscript{9} 42 C.F.R. § 412.622(a)(3)(iv).
“peer-to-peer” calls is a misnomer, since they are often not speaking to a rehabilitation physician with training and experience in IRF care. Instead, they are often speaking to physicians who have little or no experience in rehabilitation.

Making rehabilitation physicians jump through administrative hoops to have clinicians with less training and expertise overruling their medical judgement is an unsound and clinically dangerous policy. To save time and ensure accurate decisions are reached, CMS should require that a clinician with specialized training in rehabilitation be utilized to review prior authorization requests. For peer-to-peer discussions, this should include a physician that meets Medicare’s definition of rehabilitation physician and would be appropriately qualified to themselves serve the rehabilitation physician role. CMS should also require that for any denial or adverse appeal decision, the name and qualifications of the reviewer be included to ensure he or she is adequately trained and experienced.

2) **Prohibit the Use of Proprietary Decision-Making Tools by MA Plans**

MA plans often utilize propriety guidelines, such as those marketed by Milliman and Interqual, to justify denying patients’ access to IRFs. In our members’ experience, these guidelines recommend upwards of 95 percent of cases qualifying for IRF care be directed to a lower intensity setting, such as a skilled nursing facility (SNF). This practice runs contrary to CMS coverage guidelines, which requires MA plans to offer the same level of care to its patients as traditional Medicare.\(^\text{10}\) It also leads to additional strain on physicians who must justify their medical decision making against algorithms that are often based on outdated or questionable published studies.

3) **Mandate MA Plans Issue More Timely Decisions and Be Staffed at All Hours to Handle Pressing Prior Authorization Requests**

As CMS knows, hospitals are 24/7-hour operations and a patient’s condition does not pause during evenings and weekends. Despite the vulnerable state of patients in hospitals, MA plans typically take several days to render decisions, and their operations often cease in the early evenings and on weekends. This means that physicians must block off large portions of their workday, when therapists and other team members are in the building and therapy is ongoing, in order to go through the MA administrative processes. If private health plans choose to participate in the Medicare Advantage program, these plans should have 24/7 availability of qualified clinical personnel to timely consider prior authorization requests as well as appeals of negative prior authorization determinations.

Instead of spending precious weekday hours engaged in the delivery of care, physicians are tied up in the bureaucratic MA prior authorization process. Not only is this a burden on the physician’s workflow, it is also detrimental to patients. A typical example is a patient who receives a prior authorization denial on a Friday. At this point, they may have already been waiting a day or two for an IRF admission decision. Then, since the MA plan ceases operations over the weekend, a peer-to-peer appeal discussion may not be scheduled until Monday or Tuesday, where the physician must yet again take time out of their busy weekday schedule to speak with the MA physician. Once that occurs, and the

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\(^\text{10}\) Medicare Managed Care Manual Chapter 4, Revision 121, Issued: 04-22-16.
patient has finally been moved, the patient may have spent an extra full week unnecessarily in an acute-care hospital and their needed intensive rehabilitation services are delayed accordingly. This pattern is a lose-lose for all stakeholders – patients are adversely impacted by treatment delays, physicians are diverted from patient care, and the additional hospital stay results in avoidable Medicare expenditures.

To address this urgent issue, MA plans should be required to render IRF admission decisions and appeals in a timely fashion, and in no longer than 24 hours. While we believe all patients would benefit from this change, hospitalized patients are especially in need of expedited decision timeframes. CMS should also require MA plans to always have a specialized physician on call, just as the hospital is required to do. This would allow rehabilitation physicians to focus their days on participating in patient care and not on the phone with MA plans. It would also speed up the appeals process to avoid further delays, which would be beneficial to patients and their outcomes as well as to the rehabilitation physicians.

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Thank you for your consideration of our proposals. For more information, please contact Reva Singh, Director of Advocacy and Government Affairs at AAPM&R at rsingh@aapmr.org or 847.737.6030 or Jonathan Gold, AMRPA Regulatory and Government Relations Counsel, at jgold@amrpa.org or 202.860.1004.

Sincerely,

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