Executive Summary

AMRPA, AAPM&R, and FAH Response to OIG Report on Inpatient Rehabilitation Facilities (IRFs)

The American Medical Rehabilitation Providers Association (AMRPA), the American Academy of Physical Medicine and Rehabilitation (AAPM&R), and the Federation of American Hospitals (FAH) have strong objections to the findings and conclusions of the Department of Health and Human Services’ Office of Inspector General’s (OIG’s) recent report on inpatient rehabilitation hospitals and units.

IRFs play a vital role in rehabilitation care. Every year, hundreds of thousands of Medicare beneficiaries benefit immensely from IRF stays after serious injuries or illness. The unique combination of intense rehabilitation and close medical supervision offered at IRFs enables patients to return to their lives following a serious medical event. Outcomes for most patients in IRFs are significantly better than for those served in lower-intensity levels of care. IRF patients return home earlier, remain home longer, and are less likely to be readmitted to the hospital. Most importantly, IRF patients live longer than similar patients treated in other settings. The evidence is clear that IRFs play an essential role that cannot be replicated in other settings of care.

The OIG’s conclusion is unreliable and the result of flawed methodology: The OIG arrived at a flawed conclusion that 84% of IRF services in 2013 were not medically necessary. OIG’s supposed error rate is nearly five times higher than the error rate for 2013 found by the Centers for Medicare and Medicaid Services’ (CMS’) IRF auditor. This vast discrepancy was not explained or even acknowledged by the OIG and shows that OIG’s methods were flawed. This report examined just 220 out of 442,259 IRF claims from 2013 (less than 0.05%) and then extrapolated these findings to nearly one-half million other claims. The specifics of individual patients are unique; therefore, extrapolating findings from a small number of IRF cases to a broader universe of patients is inappropriate.

OIG second-guessed physician judgment without necessary expertise: Medicare’s coverage regulations rely heavily on the decision-making skills of highly-trained rehabilitation physicians who utilize years of clinical experience and consider patient-specific factors to determine the appropriateness for an IRF admission. By ignoring physician expertise, the OIG contractor conducting the audit second-guessed physician decisions based on paper records alone. The auditor also had the benefit of information gathered during the patient’s stay, which would not be available to the treating physician at the time of admission. OIG has not revealed the qualifications of its reviewers; however, based on the information available to us, we suspect the reviewers lack the requisite experience and training to conduct these audits. We believe that OIG utilized personnel without experience in medical rehabilitation or proper understanding of the intricacies of IRF care and who are not qualified to overrule the judgment of treating physicians. In addition, the claims evaluated by OIG auditors were not subject to appeal and were not released to external stakeholders for review.

Regulatory burdens such as additional audits and prior authorization will jeopardize access to high-quality and life-improving medically necessary care: IRFs are currently audited extensively and frequently by different types of contractors—more than any other Part A provider. Contrary to recommendations by OIG, an increase in the number of audits conducted by Medicare contractors would force IRFs to redirect valuable resources from patient care. Similarly, prior authorization would delay and deny medically necessary IRF care to patients. Indeed, the OIG recently issued a report criticizing Medicare Advantage Organizations for using prior authorization to deny medically necessary care. CMS should not repeat that error to the detriment of patients who need IRF care.

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