Prior Authorization Threatens Patient Access to Intensive, Medically Necessary Inpatient Rehabilitation Care, and Patient Outcomes

The American Medical Rehabilitation Providers Association (AMRPA), American Academy of Physical Medicine & Rehabilitation (AAPM&R), and Federation of American Hospitals (FAH) are opposed to the proposal in the President’s Budget for Fiscal Year (FY) 2020 to expand the use of prior authorization in Medicare for inpatient rehabilitation facility (IRF) services. Medicare beneficiaries receiving inpatient rehabilitation are recovering from serious injury or illness and are often medically complex and have significant functional deficits. Intensive, interdisciplinary inpatient medical rehabilitation enables beneficiaries to improve function, relearn critical life skills, gain independence, and return to their homes and communities. Prior authorization leads to improper denials, referrals to less effective care settings that can compromise patient outcomes, and lengthy delays that cause irreversible harm to beneficiaries.

- Prior authorization ignores medical judgment and stringent Medicare requirements that govern IRF admissions. Before a beneficiary can be admitted to an IRF, Medicare regulations require a qualified physician to evaluate the patient against objective pre-admission criteria. Among other requirements, the beneficiary must be able to tolerate and benefit from intensive therapy, at least three hours per day, with extensive documentation to confirm this. These criteria act as a de facto prior authorization that relies on the judgment and expertise of the treating physician to ensure IRF admissions are based on patient needs. The rigor of the existing IRF admission criteria help ensure IRFs admit appropriate patient types. Moreover, the negative impact of aggressive audits and resulting high denial rates can discourage IRFs from admitting patients.

- As shown in Medicare Advantage (MA), prior authorization delays recovery, denies access, and compromises health outcomes. Prior authorization in MA exemplifies its problems. Though MA enrollees are legally entitled to the same benefits as traditional fee-for-service (FFS) Medicare beneficiaries, MA plans utilize preauthorization based on proprietary guidelines. Their processes result in excessive delays while MA plans slowly respond to initial IRF admission requests and create serious problems for beneficiaries stuck in the hospital, waiting on a determination. Even more problematic, MA plans often deny the initial request and trigger even longer delays or force a patient to be discharged to a lower acuity setting where they will not get the intensive care they need to fully rehabilitate. In contrast to the robust Medicare criteria, proprietary guidelines relied on by MA plans contradict well-established best practices in rehabilitation medicine, such as the American Heart Association and American Stroke Association’s guidelines for stroke recovery, which direct that stroke patients receive their immediate post-acute care in IRFs.

- Prior authorization would further jeopardize access to medically necessary IRF care. MedPAC data demonstrate that MA enrollees are admitted to IRFs at one-third the rate of FFS beneficiaries. This discrepancy is due in large part to MA plans’ preauthorization practices. Expanding prior authorization to FFS Medicare would create even more barriers to care. Academic research confirms that MA plans do not facilitate appropriate post-acute care for medically complex patients and systematically push these high-cost patients back into traditional FFS. Expanding prior authorization to FFS Medicare would result in the same type of IRF coverage denials faced by MA beneficiaries, which can have devastating, lifelong consequences. Indeed, the literature affirms that timely and early access to inpatient rehabilitation results in better patient outcomes, such as functional ability and quality of life, and shorter lengths of stay, thereby enabling patients to return to their homes and communities sooner.

The rationale for expanding prior authorization to inpatient rehabilitation services is misguided. The Budget’s claim that prior authorization may reduce utilization of inpatient rehabilitation services that are “prone to high improper payments” is flawed because it is based on Medicare contractors’ suspect practice of denying claims for highly technical documentation deficiencies. The shortcomings of using contractor denial rates are evidenced by IRFs’ high rates of overturning denied claims on administrative appeal. We urge Congress to focus on proven, common-sense audit reforms to help ensure Medicare program integrity rather than adding more layers of bureaucracy that undermine beneficiaries’ access to high-quality care.

AMRPA, AAPM&R and FAH urge policymakers to protect access to medically necessary, inpatient rehabilitation services and to reject shortsighted policies that subject hospitalized Medicare beneficiaries to prior authorization for IRF care.

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