AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

November 16, 2022

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard, Room C4-26-05
Baltimore, Maryland 21244-1850

Re: Notice of the Proposed Changes to Forms CMS–437A & CMS-437B (OMB control number: 0938–0986)

Dear Administrator Brooks-LaSure,

We are writing in response to the notice posted in the Federal Register on August 9, 2022, regarding revised forms CMS-437A and CMS-437B, following an extension for comments issued on October 11, 2022. AMRPA is the national trade association representing more than 700 freestanding inpatient rehabilitation facilities and rehabilitation units of general hospitals (IRFs), which focus on the care and functional recovery of some the most vulnerable Medicare beneficiaries – such as traumatic brain injury, stroke and spinal cord injury patients. CMS forms 437A and 437B are critically important to AMRPA members, as these forms contain the criteria under which IRFs may continue to operate as excluded hospitals and units under the Medicare program as well as retain certifications from accrediting organizations.

AMRPA would like to thank CMS for its prompt response to AMPRA's request to extend the comment deadline for these forms. This additional time has allowed the IRF field to closely examine the forms to identify potential discrepancies and concerns. To that end, we have compiled a summary of the issues our members identified in the updated forms, along with AMRPA's corresponding recommendations for form 437A and 437B, respectively. We note that some of the same issues were identified in both form 437A and 437B, and we outlined these issues in both sections of our letter to make sure these potential issues are remedied as they apply to both freestanding hospitals and units.

Beyond the technical issues cited below, we also offer an overarching recommendation that CMS provide clearer instructions as to which personnel may complete this form, as well as whether a signature from the IRF personnel should be included in the document. This issue has been raised by our members prior to the August 2022 form updates, and we believe the form update presents an opportunity for clarification.

If you have any questions about AMRPA's recommendations or would like to discuss any of these comments, please do not hesitate to reach out to Kate Beller, AMRPA Executive Vice

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President for Policy Development and Government Relations (kbeller@amrpa.org). We look forward to continuing to collaborate with CMS on these and other important issues.

Sincerely,

Anthony Cuzzola
Chair, AMRPA Board of Directors
VP/Administrator, JFK Johnson Rehabilitation Institute

Attached: AMRPA's Comments and Recommendations regarding revised forms CMS-437A and CMS-437B

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Attachment

AMRPA's Comments and Recommendations re: Revised Forms CMS-437A and CMS-437B

Form CMS-437A (IRF Units)

I. **Tag A3502:** The 3rd column states that surveyors should verify that the IRF unit has records that are "different" from those used by the hospital in which the IRF unit is located. However, there is no requirement for records to be different from those in the rest of the hospital. In addition, in both columns 3 and 4, CMS states that the surveyor and IRF representative must ensure that the IRF medical records are separate from and not co-mingled with records of the other hospital. Again, no such requirement exists in the cited regulation, nor is it outlined anywhere in 42 C.F.R. § 412.25, which is the regulatory subpart cited in this portion of the document. Finally, the form states that IRFs must ensure "records are not co-mingled with those of the hospital and not co-mingled with those of the hospital in which the IRF unit is located." It is unclear what the distinction in this instance is between "the hospital" and "the hospital in which the IRF unit is located."

Recommendations: AMRPA recommends that CMS remove the language regarding IRF unit medical records needing to be "different" from those in the hospital in which they are located. Instead, CMS should not add any language in excess of the clear regulatory requirement (mandating that the records be separately identified). Similarly, since there is no requirement at the cited regulation regarding the co-mingling of records, CMS should also remove that statement. Finally, CMS should also clarify its language regarding "the hospital" and "the hospital in which the IRF is located."

II. **Tag A3513:** In the 4th column, the form states that the IRF unit must receive written approval from the applicable "CMS Location." It is unclear what CMS means by "CMS Location" in this instance. On a related issue, providers report that they often are unable to receive a letter from CMS regional offices (ROs) responding to requests to add new beds, despite repeated attempts.

Recommendations: CMS should clarify its language regarding needing approval from a "CMS Location." In addition, given that CMS' ROs are often unable or unwilling to issue such written approvals, this language should be removed from these forms. If CMS is unwilling to remove this language, then at the very least the agency should send direction to CMS ROs to ensure that IRF units receive prompt responses for requests for the additional of new beds or identify a more appropriate contact for such requests.

III. **Tag A3516:** The third column of this row contains a stated purpose that is not found in regulation and is potentially misleading. Specifically, it states that "The purpose of the

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preadmission screen is to reduce the rate of hospital readmission by ensuring that the patients that are accepted to the IRF will benefit from intensive rehabilitation services." While this may be partially true, such a statement is not found in regulation and it is unclear what bearing the statement has on the issue of whether preadmission screenings are being properly conducted. Notably, no such statement is found in companion form CMS-437B, which contains an identical preadmission screening requirement for freestanding IRFs.

Recommendations: CMS should remove its statement regarding the purpose of the preadmission screening since it is not found in regulation and does not contribute to the ability to verify whether the regulatory requirements are satisfied.

IV. **Tag 3517:** This row utilizes an outdated regulation that omits the ability of non-physician practitioners (NPPs) to conduct one face-to-face visit per week in lieu of a physician, beginning in the second week of a patient's hospital admission. This permissibility is found in the cited regulatory subpart 42 C.F.R. § 412.29(e), which was amended since the last update to these forms.

Recommendations: CMS must amend this row of the form to include the updated regulatory language and instruct surveyors and IRF personnel to include this permissibility in their compliance assessment.

V. **Tags A3520, A3521 and A3522:** These rows refer to the regulatorily defined Director of Rehabilitation as the "IRF Unit Director" and "the director of the IRF unit." This is potentially confusing since there may be other personnel with director in their title working in the IRF unit.

Recommendation: AMRPA recommends that CMS only use Director of Rehabilitation to refer to this position in its forms to avoid confusion regarding these requirements.

VI. **Tag A3524:** The third row includes requirements for the plan of care that go beyond regulatory requirements. Specifically, there is no regulatory requirement that the plan of care is "updated whenever there is a change in the patient's condition." IRF patients often have fluctuating conditions and the IRF clinical staff update the plan of care when needed as required by regulation, but not every time there is a change in patients' condition.

Recommendation: AMRPA recommends that CMS remove the statement that the IRF must update the plan of care whenever there is a change in a patient's condition.

VII. **Other:** Hospitals state that they find that the form lacks clear direction as to who at the hospital is permitted to complete the form on behalf of the unit, as well as whether and where a signature should be applied to the document.

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Recommendations: AMRPA recommends that CMS provide instructions as to which personnel may complete this form, as well as whether and where a signature from the IRF unit personnel should be included in the document.

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Form CMS-437B (Freestanding IRFs)

VIII. **Tag 3601:** This row omits important information regarding the ways in which the IRF may satisfy the "60 percent rule." More specifically, the instructions state that 60 percent of all patients must have needed intensive rehabilitation for one of the conditions listed at 42 C.F.R. § 412.29(b)(2). However, 42 C.F.R. § 412.29(b)(1) states that patients with certain qualifying comorbidities also count toward this percentage. Notably, revised companion form CMS-437A does include this clarification.

Recommendation: CMS must amend the information in this row to make clear that IRFs may also satisfy the requirements of these regulations through patients with certain comorbidities, as stated at 42 C.F.R. § 412.29(b)(1).

IX. **Tag A3604:** In the 4th column, the form states that the IRF must receive written approval from the applicable "CMS Location." It is unclear what CMS means by "CMS Location" in this instance. In addition, providers report that they often are unable to receive a letter from CMS regional offices (ROs) regarding new beds, despite repeated attempts.

Recommendations: CMS should clarify its language regarding needing approval from a "CMS Location." In addition, given that CMS' ROs are often unable or unwilling to issue such written approvals, this language should be removed from the verification forms. If CMS is unwilling to remove this language, then at the very least the agency should send direction to CMS ROs ensuring that IRFs receive prompt responses for requests for approval for the addition of new beds.

X. **Tag 3608:** This row utilizes an outdated regulation that omits the ability of non-physician practitioners (NPPs) to conduct one face-to-face visit per week in lieu of a physician, beginning in the second week of the hospital admission. This permissibility is found in the cited regulatory subpart 42 C.F.R. § 412.29(e), which was amended since the last update to these forms.

Recommendations: CMS must amend this row of the form to include the updated regulatory language and instruct surveyors and IRF personnel to include this permissibility in their compliance assessment.

XI. **Tag A3611:** The third column of this row incorporates an erroneous standard that is not in regulation. The column states that "The hospital will define the term "full-time" the same as it applies to all of its employees." This is not stated in regulation, nor is it feasible for many hospitals. Physicians typically have different schedules from other clinical and administrative staff at hospitals. In addition, physicians are often not

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employees of the hospitals in question, and it is not a requirement for the Director of Rehabilitation to be an employee of the hospital.

Recommendations: CMS should remove the statement that hospitals must define "full-time" in this instance in the same manner it does for other employees since this requirement does not appear in regulation, and is also not feasible given that Directors of Rehabilitation are not required to be employed by the hospital.

XII. **Tags 3611 & 3614:** These rows refer to the regulatorily defined Director of Rehabilitation as the "IRF hospital director" and "the director of the IRF hospital." This is potentially confusing since there may be other personnel with director in their title working in the IRF.

Recommendation: AMRPA recommends that CMS only use Director of Rehabilitation to refer to this position in its forms to avoid confusion regarding these requirements

XIII. **Tag A3615:** The third row includes requirements for the plan of care that go beyond regulatory requirements. Specifically, there is no regulatory requirement that the plan of care is "updated whenever there is a change in the patient's condition." IRF patients often have fluctuating conditions and the IRF clinical staff update the plan of care when needed as required by regulation, but not every time there is a change in patients' condition.

Recommendation: AMRPA recommends that CMS remove the statement that the IRF must update the plan of care whenever there is a change in a patient's condition.

XIV. **References to Units:** This form is for freestanding rehabilitation hospitals. However, there are several erroneous references to "units" in this form. Specifically:

a. The header of the worksheet cites §412.23 followed by the caption "Excluded hospital units: Classifications." The correct title is "Excluded hospitals: Classifications."
b. The instruction sheet on page 11 is titled "REHABILITATION UNIT CRITERIA WORK SHEET CMS-437B."
c. Tag A3607 instructs the "IRF Unit Representative" to verify the information, including that the preadmission screening is provided for all patients on the "rehab unit."
d. Tag A3609 refers to "IRF unit" personnel.

Recommendation: AMRPA recommends that CMS remove and replace the references to units in form CMS-437B.

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XV. **Other:** Hospitals state that they find that the form lacks clear direction as to who at the hospital is permitted to complete the form on behalf of the IRF, as well as whether and where a signature should be applied to the document.

Recommendations: AMRPA recommends that CMS provide instructions as to which personnel may complete this form, as well as whether a signature from the IRF personnel should be included in the document.

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