AMRPA
AMERICAN MEDICAL REHABILITATION PROVIDERS ASSOCIATION

September 19, 2025

Submitted Electronically

Michael E. Chernew, Ph.D.
Chair
Medicare Payment Advisory Commission

Re: American Medical Rehabilitation Providers Association's Comments on MedPAC's September 2025 Meeting

Dear Dr. Chernew, MedPAC Commissioners, and Staff:

On behalf of the American Medical Rehabilitation Providers Association (AMRPA) and our more than 800 member hospitals, we appreciate the opportunity to provide our response to the Medicare Payment Advisory Commission's (MedPAC) September 2025 meeting session. AMRPA is dedicated to protecting patient access to inpatient rehabilitation and positioning our hospitals to meet the demands of an aging and medically complex population. As MedPAC begins analysis and discussion related to potential recommendations for inpatient rehabilitation facility (IRF) payment, we seek to provide additional context and important clarifications regarding two topics discussed at the most recent meeting:

- The IRF Review Choice Demonstration (RCD) program; and
- Inconsistencies with the interpretation and application of medical necessity requirements.

I. AMRPA Concerns with the Commission's Analysis & Discussion of the IRF Review Choice Demonstration (RCD) Program

First, AMRPA members are concerned that information shared with and discussed by Commissioners regarding the IRF RCD program does not provide an accurate picture of this program. To date, the IRF RCD has been ongoing for more than two years in Alabama and over a year in Pennsylvania, requiring that all inpatient rehabilitation hospitals undergo 100% pre-claim or post-payment review of every Fee-for-Service Medicare admission. This documentation review process with the Medicare contractor is layered on top of the already-extensive pre-admission screening process, in which rehabilitation physicians and the care team at IRFs review each patient referred for IRF care to ensure they meet Medicare's criteria for medical necessity.

While the demonstration has been in effect since August 2023, the Centers for Medicare & Medicaid Services (CMS) has thus far only released limited data on the program, in several different formats that present sometimes conflicting information. Furthermore, the public data released to date has significantly lagged behind the program itself, with the most recent CMS metrics only covering up to October 2024 in Alabama, and very little information at all released to date covering Pennsylvania, with more than three times as many hospitals participating in the program. AMRPA believes this lack of meaningful transparency obscures the true performance of hospitals under the program and the administrative burden imposed on these providers.

Overall, the most robust program-wide data that has been released to date is included in CMS' report entitled "Review Choice Demonstration for Inpatient Rehabilitation Facility Services (IRF RCD) Quarterly Updates Fiscal Year (FY) 2024 (Oct 2023 – Sept 2024)". This document, while still lagging a year behind current program results, suggests an overall "provisional affirmation rate" across FY 2024 of approximately 88%. Based on reports from member hospitals in RCD states and informal updates provided by contractors during their ongoing educational presentations, affirmation rates from the more recent third cycle in Alabama and the last year of Pennsylvania data indicate significantly higher rates of affirmation, consistently higher than 95% overall.[1]

Given these results, we urge MedPAC to gather more recent, accurate data from CMS before characterizing the RCD or its impact on Medicare expenditures in the draft report. Finally, we note that there continue to be vastly inconsistent findings between different programs and agencies reviewing the "appropriateness" of IRF payments, including the IRF RCD, Department of Health and Human Services Office of Inspector General (HHS OIG) audits, the annual Comprehensive Error Rate Testing (CERT) reports, and contractor-driven post-payment review such as the Targeted Probe and Educate (TPE), Recovery Audit Contractor (RAC), and Supplemental Medical Review Contractor (SMRC) programs. Given these widespread discrepancies, ostensibly from programs reviewing representative samples of the same types of claims and using the same Medicare coverage and payment criteria, we continue to question the value of applying disparate "objective" reviews to complicated questions of individualized medical necessity. For these reasons, AMRPA has called for the demonstration to be sunset, and we continue to engage with CMS and Congressional leaders in pursuit of this goal.

II. MedPAC Must Consider Inconsistencies with the Interpretation and Application of Medical Necessity Requirements

During an exchange on improper payments and CERT reports, MedPAC staff suggested that IRFs are "…pretty much the only setting where medical necessity problems are the reasons for improper payments." AMRPA believes that this statement is misleading and may have implications for access to IRF care and payment. While the CERT report does show that IRFs have a higher number and percentage of claims identified as improper payment for reasons of medical necessity, what is not clearly identified is what the "medical necessity" requirements are for all post-acute care (PAC providers) and whether the criteria are being applied accurately and consistently.

For example, one of the CMS CERT contractors, Palmetto GBA, has published CERT Checklists for IRFs and Skilled Nursing Facilities (SNFs). Palmetto lays out clear "Medical Necessity" criteria for IRFs, while the SNF document does not include any "Medical Necessity" criteria. This may explain why CERT reports do not categorize improper payments in other settings for Medical Necessity reasons but do so heavily in IRFs. For this reason, we believe it is inaccurate

[1] *See, e.g.,* Novitas (Medicare Administrative Contractor for Pennsylvania), Webinar on "Inpatient Rehabilitation Facility Review Choice Demonstration (IRF RCD): Cycle 2 Progress" (June 25, 2025), recording available at https://fcso.webex.com/webappng/sites/fcso/recording/edffe78275da4151ab313b5f96b363e9/playback (PA Cycle 2 discussion beginning at 18:52).

to suggest IRFs are the only setting with improper payments for medical necessity and should instead prompt a broader review of CERT review criteria.

While 'medical necessity' is cited as the reason for most denials of IRF care, this does not necessarily mean that the patient did not medically need or benefit from IRF care. In 2010, CMS promulgated updated 'medical necessity' rules that govern the qualifying criteria for IRF admission, but by laying these out in regulation, the rules attempted to translate clinical questions of patient need and physician judgment into black-and-white criteria that look more like objective documentation standards – essentially trying to fit a square peg into a round hole. Under these rules, small errors on these requirements around documenting medical necessity are often categorized as "Medical Necessity Errors," while they should more reasonably be considered technical issues.

For example, the CMS coverage criteria require that patients have a medical and functional need for supervision by the rehabilitation physician under 42 C.F.R. 412.622(a)(3)(iv), but hospitals report in practice that denials under this subsection are sometimes handed down because the reviewer did not find specific phrases in the medical record clarifying that the physician evaluated both medical and functional progress at each meeting with the patient. This would be categorized as a Medical Necessity error, but there is no suggestion that the patient's needs did not fit the CMS criteria, only that the documentation wording might not account for all the physician's activity with the patient during their stay. Similarly, if the timing of a patient's first evaluation for speech-language pathology occurred on Hour 37 of their admission, the entire stay could be denied under 42 C.F.R. 412.622(a)(3)(ii) as a Medical Necessity denial, even though the timing of an evaluation is a purely technical requirement.

In cases like these, while AMRPA understands that IRFs are nevertheless required to meet all requirements set forth by CMS, it is wholly inappropriate to suggest that such denials reflect any finding that the patient involved did not truly need intensive inpatient rehabilitation, did not demonstrably benefit from IRF services, or did not achieve excellent medical and functional outcomes. We also note that no other level of care has such an extensive number of granular and technical documentation requirements that are categorized as indications of 'medical necessity'. We believe that use of this term to describe human error that sometimes may occur with documentation or timing of documentation is a misnomer, and the categorization of denials as such does not reflect a value judgement on the importance of IRF care nor any suggestion that patients are given this care without a true medical need.

Finally, the medical necessity criteria can be very subjective and open to differences in opinion between reviewers, even when those reviewers or physicians have inpatient rehabilitation experience. This is especially the case for the requirement for medical supervision by a rehabilitation physician, which turns on the determination made by a rehabilitation physician to admit this patient. Reviewers may apply different standards for how to make a determination on this requirement, such as inappropriately suggesting that patients with certain diagnoses may not require IRF care or that care could be delivered in a less costly setting. If a rehabilitation physician documents in pre-admission screening that a patient meets the medical necessity criteria and indicates the reason for admission requiring medical supervision by a rehabilitation

physician, it raises serious concerns that a reviewer is allowed to make a retrospective, subjective determination based upon criteria that falls outside of the Medicare program requirements.

AMRPA asks that MedPAC fully consider these inconsistencies with medical necessity determinations when considering recommendations for IRF payment.

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In closing, we believe many of our concerns with MedPAC's analysis and recommendations would be addressed with a better understanding of how our hospitals operate and the distinct role that IRFs play in the care and recovery of patients who have experienced catastrophic illness or injury. As always, AMRPA would welcome the opportunity to host MedPAC staff and Commissioners on IRF tours or facilitate interviews with AMRPA hospital leaders to better illustrate our hospitals' value and corresponding impact on patients' long-term recovery and quality of life. In the meantime, we stand ready to further engage with the Commission and consider improved methods for evaluating improper payments and IRF payment adequacy prior to the October meeting.

Should you have any questions related to our concerns or recommendations, please contact Kate Beller, AMRPA President, at KBeller@amrpa.org, or Troy Hillman, AMRPA Director of Quality and Health Policy, at THillman@amrpa.org.

Sincerely,

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Vice President and Chief Operations Officer, Madonna Rehabilitation Hospitals