



June 15, 2020

SUBMITTED ELECTRONICALLY VIA www.regulations.gov

Ms. Seema Verma
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

RE: Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2021 Proposed Rule [CMS-1729-P; RIN 0938-AU05]

Dear Administrator Verma:

The undersigned members of the Coalition to Preserve Rehabilitation (CPR) Steering Committee appreciate the opportunity to comment on the proposed rule entitled, *Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2021*. This letter focuses on the Centers for Medicare and Medicaid Services' (CMS) proposal to expand the role of non-physician practitioners in inpatient rehabilitation hospitals and units (IRFs) and on documentation requirements involving admission and physician-directed treatment in the IRF setting.

CPR is a coalition of more than 50 national consumer, clinician, and membership organizations that advocate for policies to ensure access to rehabilitative care so that individuals with injuries, illnesses, disabilities, and chronic conditions may regain and/or maintain their maximum level of health and independent function. CPR is comprised of organizations that represent patients—as well as the clinicians who serve them—who are frequently in need of the intensive level of rehabilitation care provided in IRFs.

Overview

The proposed rule adopts a market basket and payment update specific to IRFs and revises relative weights for the IRF case-mix groups. CPR does not intend to comment on these sections of the proposed rule. CMS also proposes to revise IRF coverage and documentation requirements for FY 2021 and beyond, most notably allowing significant expansion of the role of non-physician practitioners in an IRF, as well as eliminating the requirement for a post-admission physician evaluation (PAPE). Our comments focus on these provisions.

Use of Non-Physician Practitioners to Perform IRF Duties Currently Performed by Rehabilitation Physicians

The FY 2021 proposed rule includes a significant proposal to expand the scope of the IRF coverage requirements to allow non-physician practitioners (NPPs) to perform many duties which are currently required to be performed by a rehabilitation physician. Specifically, the proposal would allow a non-physician practitioner (which is not explicitly defined in the proposed rule, but which we believe to refer to physician assistants and nurse practitioners) who is determined by the IRF to have “specialized training and experience in inpatient rehabilitation” to perform any of the duties that are currently required to be performed by a rehabilitation physician, provided that those duties are within the practitioner’s scope of practice under state law.

Under this proposal, non-physician practitioners would be able to conduct or designate another certified clinician to conduct the preadmission screening (PAS), review and concur with the findings of the preadmission screening, conduct the post-admission physician evaluation (PAPE), which CMS proposes to eliminate, lead the required weekly interdisciplinary team meetings, conduct required face-to-face visits with the patient, and develop and modify the patient’s plan of care. In sum, CMS proposes to defer to the IRF to determine whether a non-physician practitioner has sufficient specialized training and experience in inpatient rehabilitation to essentially fulfill the role of the rehabilitation physician.

CPR views this proposal as a major broadside attack on the integrity and value of care provided by inpatient rehabilitation hospitals and units. We strongly oppose this proposal and believe that, if finalized, it would materially undercut IRF care and decrease the level and quality of care provided in an IRF, potentially causing significant harm to patients with complex conditions who need an intensive, coordinated, interdisciplinary course of inpatient hospital-level rehabilitation treatment.

The key to effective inpatient hospital rehabilitation is the interdisciplinary team approach, led by a physician with expertise and experience in rehabilitation. Along with the intensity of therapy and the coordination of medical and rehabilitation services, the interdisciplinary team led by an experienced rehabilitation physician is fundamental to IRF care. CPR believes that an IRF-level of care necessitates a level of physician involvement and direction that is often lacking in sub-acute care settings. CPR believes that rehabilitation physicians must retain their critical role in directing IRF care along with the rehabilitation team and we urge CMS to withdraw its proposal to allow non-physician practitioners to perform the duties of the rehabilitation physician in an IRF.

CPR has serious reservations about the use of non-physician practitioners to satisfy requirements currently required to be met by rehabilitation physicians, which we have expressed previously in our [comments](#) on the FY 2019 IRF PPS proposed rule. These concerns are grounded in the distinctions between the training and experience of rehabilitation physicians, who are frequently Board-certified specialists, and non-physician practitioners with no such specialized training or certification (e.g., physician assistants and nurse practitioners). Certainly, non-physician

practitioners already play a critical role in IRF care and can gain crucial experience in rehabilitation medicine over time, but these practitioners must be used in a manner that does not undermine direct physician-patient engagement in the IRF. CPR believes the IRF level of care must continue to be defined by the rehabilitation team concept, led by a physician with expertise and experience in rehabilitation.

For these reasons, we strongly urge CMS to withdraw the proposal in the FY 2021 IRF PPS proposed rule to allow non-physician practitioners to fulfill IRF coverage requirements currently required to be performed by the rehabilitation physician.

CMS Should Eliminate Both the PAPE and PAS in Exchange for a Comprehensive History and Physical

The proposed rule includes a proposal to remove the requirement to conduct a post-admission physician evaluation (PAPE), which is currently required to be performed by the rehabilitation physician within 24 hours of the patient's admission to an IRF. The PAPE documents the patient's status upon admission to the IRF, including a comparison with the information in the preadmission screening (PAS). As CMS notes in the proposed rule, and as rehabilitation stakeholders have raised in the past, much of the information in the PAPE is typically duplicative of the information that would be collected in a diligent PAS.

Therefore, the PAPE is often viewed as an unnecessary documentation burden for the rehabilitation physician that may not provide additional clinical utility to the rehabilitation provider team. Under CMS' proposal, IRFs would no longer be required to document a PAPE to justify an IRF admission, though facilities would not be precluded from performing such examinations as they would deem necessary.

When CMS implemented the current IRF coverage criteria in 2010, the agency made the decision to shift to a regimented documentation process (including the PAS and PAPE) intended to ensure that the appropriate patients received the appropriate level of care and services in an IRF. However, this system has created layers of administrative burden, including duplicative documentation, inflexible time deadlines, and other hurdles that have instead served to separate physicians from their patients. Importantly, these requirements have also led to a massive number of claim denials based on technical documentation deficiencies, even while the care in question is clearly reasonable and necessary.

Rather than considering elimination of the PAPE alone, CPR encourages CMS to completely rethink the IRF documentation requirements by retiring both the PAS and PAPE together. We encourage CMS to consider broader changes to the documentation requirements for IRF coverage in order to create a more patient-centered system. Post-acute care providers in IRFs know that the intensive level of rehabilitation care provided in these settings is appropriate for highly complex patients with acute medical needs. Many believe that a complete and thorough examination by a trained rehabilitation physician includes more than sufficient clinical information to justify an IRF admission and may in fact be more useful towards developing the patient's plan of care.

We therefore urge CMS to consider broadly revising the documentation requirements to retire the PAS and PAPE and, instead, rely on a comprehensive history and physical (H&P) to serve as justification for both an IRF admission and to assist in developing an individualized plan of care for each patient.

However, if CMS decides not to proceed with more overarching revisions, we encourage the agency's efforts to reduce the time spent by providers on administrative requirements and increase the time spent providing patient care. We agree that the PAPE is duplicative and do not oppose its elimination. Additionally, as CMS receives feedback on the comment solicitation regarding elements for the PAS, we hope the agency will ensure that any revisions in the future maintain the focus on the particular level of care provided in an IRF, rather than including potential changes that might weaken the distinctions between IRFs and other post-acute care settings. We encourage CMS to conduct a transparent process, including widespread stakeholder input, open door forums, and additional solicitations, as well as involve organizations representing consumers, before proposing or finalizing any additional regulatory changes to the PAS requirements.

Codifying the MBPM into Regulations

CMS also proposes to codify into binding regulations guidance regarding the preadmission screening that currently resides in the Medicare Benefit Policy Manual (MBPM) and is generally considered non-binding. The existing guidance does not specify elements for the PAS, but states that the screening "must include a detailed and comprehensive review of each patient's condition and medical history, including the patient's level of function... expected level of improvement... evaluation of the patient's risk for clinical complications; the conditions that caused the need for rehabilitation; the treatments needed," and more.

Minor deficiencies in recording specific elements of both the PAS and PAPE required under the MBPM has led to a raft of provider claim audits and denials over the past 15 years, which has caused rehabilitation physicians and IRFs to spend untold amounts of hours appealing these denials for otherwise medically necessary rehabilitation care. This has created a chilling effect on IRF admissions and, we would assert, compromised patient access to inpatient hospital rehabilitation. By codifying the PAS MBPM guidelines into binding regulation, this problem is exacerbated, not eased.

We appreciate CMS' overall commitment to reducing documentation and administrative burden to allow practitioners in IRFs to spend less time on paperwork and more time providing direct rehabilitation care to patients. However, while elimination of the PAPE serves this purpose, codification of the MBPM to regulations does the exact opposite. It creates additional burdens on health care providers that has a downstream negative impact on patients. We urge CMS to refrain from finalizing any regulation that elevates non-binding guidance into binding regulation, particularly with respect to IRF admission requirements.

We greatly appreciate your consideration of our comments on the FY 2021 IRF PPS proposed rule. Should you have any further questions regarding this information, please contact Peter Thomas or Joe Nahra, coordinators for CPR, by e-mailing Peter.Thomas@PowersLaw.com or Joseph.Nahra@PowersLaw.com, or by calling 202-466-6550.

Sincerely,

The Steering Committee of the Coalition to Preserve Rehabilitation

Brain Injury Association of America
Center for Medicare Advocacy
Christopher and Dana Reeve Foundation
Falling Forward Foundation
National Multiple Sclerosis Society
United Spinal Association