

February 4, 2020

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Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
7500 Security Boulevard  
Baltimore, MD 21244-1850

*Submitted electronically*

**Re: Reducing Physician Burden by Reducing Medicare Denials of Inpatient Rehabilitation Hospital Claims**

Dear Acting Director Bennett:

The American Academy of Physical Medicine and Rehabilitation (AAPM&R) would appreciate the opportunity to meet with you and members of your staff to discuss constructive ways to reduce the number of claims denied in post-acute care, particularly inpatient rehabilitation facilities (hospitals and units or “IRFs”). Our interest in meeting stems from our concern regarding denied IRF Medicare fee-for-service claims based on medical necessity and technical errors. It is our belief that reducing the number of claims requests denied in IRFs will reduce physician burden and burnout, allowing physicians to spend more time with patients rather than doing paperwork. Additionally, we have outstanding questions regarding residents’ capabilities in IRFs.

AAPM&R is the national medical specialty organization representing more than 9,000 physicians who are specialists in physical medicine and rehabilitation (PM&R). PM&R physicians, also known as physiatrists, treat a wide variety of medical conditions affecting the brain, spinal cord, nerves, bones, joints, ligaments, muscles, and tendons. PM&R physicians evaluate and treat injuries, illnesses, and disabilities, and are experts in designing comprehensive, patient-centered treatment plans. Physiatrists utilize cutting-edge as well as time-tested treatments to maximize function and quality of life. By virtue of their extensive training and expertise in rehabilitation, impairment and function, physiatrists have a well-established clinical and leadership role in IRFs and commonly serve as medical directors and rehabilitation physicians in IRFs.



AAPM&R appreciates CMS' ongoing emphasis on finding and implementing ways to reduce physician burden and excessive or unnecessary documentation across the program. There is perhaps no greater need for this activity than in the area of IRF care. Our proposals are designed to enable clinicians to better focus on the delivery of high-quality, patient-centered care. To that end, we would like to reiterate comments we have submitted and discussed previously with CMS staff in 2019,<sup>1</sup> which we believe would address a significant source of burden among our members who furnish care in the IRF setting. We hope you will incorporate these proposals into the upcoming IRF proposed rule for FY 2021.

*I. Proposals to Reduce Burden in Medicare Fee-For-Service by Addressing Inpatient Claims Denials*

*A. CMS Should Ensure Physicians Are Not Required to Record Redundant Documentation*

Rehabilitation physicians are perpetually stymied by the voluminous and burdensome CMS documentation requirements for IRF coverage under Medicare. The coverage rules, which impose a framework the physician must follow through the entire patient's stay, arguably dictate more about how rehabilitation physicians should practice medicine than exists in any other setting of care covered by Medicare. Perhaps of most frustration to our members, the regulations require redundant and sometimes clinically irrelevant information to be contained in the patient's medical record. Examples of the numerous and sometimes conflicting compliance requirements for IRFs include:

- The physician must review and concur with a comprehensive pre-admission screening (PAS) that must occur no earlier than 48 hours of admission to the IRF.
- The physician must then conduct a post-admission physician evaluation (PAPE) no later than 24 hours after the patient is admitted to an IRF and compare the findings to the PAS.

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<sup>1</sup> In 2019, AAPM&R submitted comments on Medicare denials of IRF claims on February 12 and met with CMS staff on March 5 to discuss this and several other issues. Additionally, we submitted the same comments as an attachment to our comments to the CY 2020 IRF PPS Proposed Rule (CMS-1710-P). Finally, AAPM&R submitted joint comments with the American Medical Rehabilitation Providers Association to the CMS RFI to Reduce Administrative Burden to Put Patients Over Paperwork (CMS-6082-NC) on August 12.

- No later than 4 days after the patient's admission, the rehabilitation physician must have developed an individualized overall plan of care (IPOC) for the patient and have it placed in the medical record.
- The physician must conduct a minimum number of visits per week and make specific determinations.<sup>2</sup>
- The physician faces specific requirements with respect to the type and frequency of weekly clinical team meetings that must be convened.<sup>3</sup>

These requirements stand in stark contrast to requirements for admission to an acute-care hospital, which simply requires production of a history and physical of the patient. While we recognize that these rules are intended to ensure that only appropriate patients are admitted and remain in IRF care (and that IRF patients receive the intensive services they need), we believe the overly prescriptive nature of these requirements, and the time limits imposed, result in clinicians jumping through hoops to meet CMS requirements rather than focusing their efforts on individualized, timely treatment of each patient.

We strongly believe that rehabilitation physicians, in accordance with their expertise and training, as well the policies and procedures of their hospital, should have greater flexibility to provide timely and intensive hands-on care for IRF patients. We believe that offering physicians regulatory relief in this area will result in more patient-centered care, in line with the goals of this Administration.

We are equally concerned with the fact that Medicare contractors routinely deny payment for entire IRF visits for small, technical documentation errors, such as missing one of the numerous documentation deadlines by a few hours – even if the patient's chart otherwise clearly demonstrates the need for IRF care. This is particularly onerous now that electronic medical records time stamp every amendment to the medical file. The proposals below would provide relief from redundant and unnecessary requirements while maintaining the spirit of CMS's current documentation framework.

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<sup>2</sup> The regulated minimum is often confusing to our members, who typically see patients far more than the minimum three visits per week by their own judgment. It may be helpful to emphasize that three visits per week is a minimum, and physicians should use their discretion as to how many physician visits individual patients need, beyond the initial three.

<sup>3</sup> 42 C.F.R. § 412.622.

***B. Provide Additional Flexibility for Arbitrary Time Requirements, Especially on Weekdays and Holidays***

The rehabilitation physician treating the patient is in the best position to evaluate the patient and put into motion their plan of care. However, these specialized physicians are forced to mold their approach to fit CMS' rigid timeframes. There are two major unnecessary timeline burdens placed on rehabilitation physicians that could be alleviated with small changes to the CMS regulations: (1) establishing time-related requirements in days, rather than hours, to avoid arbitrary cut-off periods during a workday, and (2) offering greater flexibility for documentation timeframes during weekends and holidays.

First, CMS uses a 48- and 24-hour standard for the PAS and PAPE, respectively. If CMS were to rephrase these regulations as a "day" standard, it would go a long way to alleviate pressure on physicians to timely submit their IRF documentation. To illustrate, currently a physician must be aware of the time a patient was admitted to an IRF in order to ensure the PAPE is completed no later than that exact time 24 hours later.

If CMS' deadline for the PAPE were instead phrased as "midnight the next calendar day," rehabilitation physicians would not be caught in the position of having to interrupt direct patient care in order to fill out and submit documentation by an onerous deadline having nothing to do with patient quality or outcomes. CMS could similarly implement this change for the deadlines applicable to the PAS and IPOCs, so providers are not required to fixate on exact times, and instead have flexibility within the next calendar day(s) to complete the requirements in a way that does not interfere with patient care, while maintaining the spirit of the regulation and ensuring patients are seen and tended to in a timely fashion.

CMS could allow even greater flexibility by incorporating relief for deadlines on weekends and holidays. For instance, CMS could add a clause to its regulations to require that the documentation be completed by "midnight the next *business* day(s)." This language would resolve the time pressures that impact physicians as a result of both an hourly standard and the problem of weekends and holidays. As an example, if a patient is admitted to an IRF late on a Friday, the physician must complete the PAPE by late on a Saturday. Often, the clinical difference between the PAPE taking place on a Monday morning instead of a Saturday evening is negligible. This would allow rehabilitation physicians to focus on the most pressing needs of patients and

complete the PAPE during the next business day, if clinically appropriate. As another example, if the PAS took place on Friday, providers need to ensure that the patient is officially admitted on Monday no later than the time the PAS took place on Friday, or otherwise run afoul of the regulation. Adding an end-of-the-next-business-day standard would similarly provide appropriate flexibility for clinicians so they are free to finish admitting the patient by the end of the day Monday, rather than by a seemingly arbitrary time deadline.

***C. Eliminate Denials for De Minimis Omissions in the Medical Record When Medical Necessity is Clearly Demonstrated***

As previously mentioned, rehabilitation physicians and IRFs are put in the precarious position of having payment for an entire IRF stay denied due to relatively minor missing or deficient documentation, such as a PAPE being conducted an hour late or a missing signature on team meeting notes. This is the case regardless of whether the totality of the medical record clearly indicates the need for IRF services, and that the patient received the appropriate level of services. Consistent with CMS' Patients Over Paperwork initiative, CMS should eliminate this draconian standard and take a more pragmatic approach to evaluating IRF claims.

CMS could take several approaches to eliminating these technical denials and allow rehabilitation physicians to focus more on their patients and less on paperwork. The first approach would be to amend the current IRF regulations with a statement that claims will not be denied due to a minor technical deficiency, and a determination of medical necessity for IRF services shall be based on the totality of the medical record. Second, CMS should instruct contractors to ignore de minimis or non-material omissions or deficiencies in the medical record when the totality of the record indicates medical necessity requirements were satisfied. In this instance, the Comprehensive Error Rate Testing (CERT) contractor and the Office of Inspector General (OIG) would also have to be instructed or otherwise agree to employ this same standard in their review of IRF claims.

We appreciate CMS' efforts to ensure physicians are not diverted from patient care by duplicative or unnecessary recordkeeping and reporting requirements. To this end, we ask CMS to allow rehabilitation physicians practicing in IRFs to focus on delivering needed care to beneficiaries and eliminate technical denials when medical necessity is otherwise demonstrated. Inclusion of these proposals in this year's IRF proposed rule would dramatically reduce burden

and physician burn-out, while not impacting the quality of patient care or substantially increasing cost. We urge CMS to include these proposals in this year's rule.

## *II. Residents' Capabilities in IRFs*

In 2019, we learned that CMS requirements appear to be placing greater restrictions on the activities that residents may perform in IRF settings compared to restrictions in other settings. We ask CMS to update its regulations to clarify this issue. We previously submitted these questions in several letters throughout 2019 and through the IRFcoverage email address.<sup>4</sup>

Because IRF regulations at 42 C.F.R. §412.622 require that a “rehabilitation physician” complete certain tasks, including conducting a post-admission physician evaluation, conducting face-to-face visits, and developing a patient's overall plan of care, some IRFs are prohibiting residents from engaging in these activities and documenting information about such activities in patients' medical records. As a result of such action, these IRFs are unintentionally placing an undue burden on the rehabilitation physicians. Due to the lack of clarity causing some IRFs to limit residents' participation in and documentation of core IRF services, the responsibility of the extensive paperwork falls entirely to the rehabilitation physician and also decreases the opportunity for residents to learn and practice these critical skills.

We believe this is inconsistent with the flexibility afforded to residents working under the supervision of teaching physicians in other inpatient and outpatient settings (see Chapter 12 of the Medicare Claims Processing Manual, Section 100). For example, residents may perform evaluation and management visits, surgical procedures, and other complex or high-risk procedures when a teaching physician is physically present during the critical or key portions of a service. Likewise, documentation made by a resident may support payment for teaching physician services under the Physician Fee Schedule provided the teaching physician signs the notes and the documentation meets certain requirements regarding content and teaching physician participation.

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<sup>4</sup> In addition to our April 11, 2019 submission to [IRFcoverage@cms.hhs.gov](mailto:IRFcoverage@cms.hhs.gov), AAPM&R submitted comments on this topic on February 15, 2019 and spoke with CMS staff regarding the comments on March 5, 2019. Additionally, AAPM&R submitted comments requesting this clarity in our response to the CY 2020 IRF PPS Proposed Rule (CMS-1710-P). Finally, AAPM&R submitted comments to the CMS RFI on Reducing Administrative Burden to Put Patients over Paperwork (CMS-6082-NC).

Additionally, CMS finalized in the Calendar Year 2020 Medicare Physician Fee Schedule (MPFS) rule to establish a general principle to allow billing professionals to review and verify, rather than re-document, information included in the medical record by physicians, residents, nurses, students, or other members of the medical team. CMS also agreed with commenters that additional clarity as to the specific types of students and clinicians that would be included is warranted. This regulation recognizes the value of resident and student documentation and the burden that redocumentation by the billing clinician (versus review and verification) imposes; if finalized, it would reduce documentation burden for services billed under the MPFS. However, it would not provide any additional clarity around the requirements that apply to IRFs, nor provide any basis for IRFs to ease restrictions on resident responsibilities that they may have put in place, as noted above.

AAPM&R appreciates the policies and proposals CMS has put forth to value residents' and students' contributions to the delivery of care and to reduce documentation burden for clinicians furnishing care to Medicare beneficiaries. We are hopeful that CMS agrees that such policies should likewise apply in IRF settings, and that residents training in IRF settings should be allowed to complete and document key portions of IRF care, including conducting a postadmission physician evaluation, conducting face-to-face visits, and developing a patient's overall plan of care, with appropriate physician oversight. In order to achieve this goal, ***we ask that CMS update its IRF regulations and/or guidance to provide clarification on the following questions, such that IRFs have confidence in residents' ability to perform and document these key IRF services.***

#### **A. Post-Admission Physician Evaluation**

1. Can a resident conduct the post-admission physician evaluation (PAPE) if a supervising teaching physician is physically present during the entire evaluation?
2. Can a resident conduct the PAPE if a supervising teaching physician is physically present during only the critical or key portions of the evaluation? If yes, what elements does CMS specify are the critical or key portions of the evaluation?
3. Under what conditions can a resident complete the documentation regarding the completion and findings of the PAPE?

**B. Three Minimum Required Physician Face-to-Face Visits Per Week**

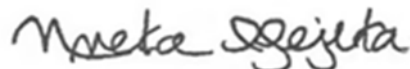
1. Can a resident conduct the face-to-face visits if a supervising teaching physician is physically present during the entire evaluation?
2. Can a resident conduct the face-to-face visits if a supervising teaching physician is physically present during only the critical or key portions of the visit? If yes, what elements does CMS specify are the critical or key portions of the visit?
3. Under what conditions can a resident complete the documentation regarding the completion and findings of the visit?

We would note that AAPM&R members across the country have raised concerns that CMS guidance appears to place restrictions on residents' ability to perform the above activities, which creates a disparity between activities that may be performed by residents in IRF settings versus other inpatient and outpatient settings. Furthermore, we are concerned that – if such activities may not be performed by residents – the IRF-specific restrictions limit the ability of rehabilitation residents to gain training and expertise in these critical elements of rehabilitation care.

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Again, we would like to meet with you to discuss these issues and further consider proactive solutions to address them. A member of our staff will be reaching out shortly to schedule a meeting. To follow up with any questions you may have, please contact Reva Singh, Director of Advocacy and Government Affairs at AAPM&R, at [rsingh@aapmr.org](mailto:rsingh@aapmr.org) or 847.737.6030. Thank you for your consideration of our comments.

Sincerely,



**Nneka Ifejika, M.D., M.P.H., FAHA**  
**Chair, Health Policy and Legislation Committee**