ALLIANCE FOR RECOVERY CARE

DEBATE SERIES

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INPATIENT REHABILITATION FACILITIES (IRFs) AND REVIEW CHOICE DEMONSTRATION (RCD)

In September 2021, CMS again proposed a "Review Choice Demonstration" (RCD) for Inpatient Rehabilitation Facilities (IRFs). The main arguments for and against this proposed demonstration are presented here.

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"The new IRF-RCD is necessary since the HHS-OIG has found a high rate of improper IRF admissions."

FROM THE U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

The following policy position is extracted and summarized from the several regulatory filings which explain why the US Department of Health & Human Services (HHS) has proposed this new policy. The Centers for Medicare & Medicaid Services (CMS) proposes this new policy after two investigations of the rehabilitation hospitals, conducted by the HHS Office of Inspector General (OIG).

In December 2020, the Centers for Medicare & Medicaid Services (CMS) announced a new "Review Choice Demonstration" (RCD) that will require Inpatient Rehabilitation Facilities (IRFs) to have their claims subjected to additional scrutiny by a Medicare Administrative Contractor. This new RCD policy will initially be implemented for IRFs in Alabama and then expanded to Pennsylvania, Texas, and California. In September 2021, the Biden Administration signaled its support for the policy by issuing a new notice and inviting a second round of public comment.

The IRF-RCD is designed to remind all IRFs of Medicare's coverage and documentation

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"The IRF-RCD is a blunt tool that will restrict patient access to inpatient rehabilitation hospital care."

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The IRF-RCD is a stunning overreach by the Centers for Medicare and Medicaid Services (CMS) that will empower auditors to second-guess the medical judgments of trained and experienced rehabilitation physicians and, ultimately, restrict IRF access for Medicare patients with severe illnesses and injuries. CMS justifies this massive audit program on its authority to fight fraud but has demonstrated no fraud in IRF admissions.

At the heart of recent IRF denials are disagreements between non-physician auditors and treating rehabilitation physicians about the types of patients who are appropriate for IRF care. CMS should

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requirements. And Medicare compliance officials will focus its anti-fraud efforts on only those IRF providers with persistent compliance problems.

For instance, in the beginning of the IRF-RCD, 100% of an IRF's claims will be subject to RCD review. This will be done through either a pre-claim or a post-claim review of the provider's supporting documentation for a claim, based on the individual provider's choice.

However, once an IRF demonstrates a 90% claim approval rate, on a minimum of 10 claims, the IRF will be able, if it so chooses, to opt out of the full claim review process. In that event, their Medicare Administrative Contractor (MAC) will continue to randomly spot-check 5% of the IRF's claims – in keeping with other, long-standing, CMS fraud prevention practices.

Some IRFs have argued the IRF-RCD is unnecessary, unlawful and/or overburdensome. But these assertions ignore the the history of sizable improper payments in this area, as well-documented by the US Department of Health and Human Services Office of the Inspector General (HHS-OIG).

In 2020, HHS-OIG estimated that IRFs had the second highest rate of improper payments among all providers serving the Medicare program, with more than 30% of payments being improper. This is nearly five times the overall estimated improper payment rate of 6.27% across all of Medicare. In most cases, HHS-OIG reviewers found that the claims associated with these improper payments lacked medical necessity or proper documentation. The HHS-OIG estimated that Medicare made $2.4 billion in improper payments to IRFs in FY2020 alone.[1]

The new IRF-RCD will help reduce this rate of improper payments and ensure that IRF services are provided to Medicare beneficiaries consistent with all Medicare coverage, coding and payment rules.

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completely rethink the RCD and pursue alternative approaches to program integrity that do not compromise patient care or create extensive burdens on providers who serve these vulnerable patients.

To qualify for IRF care, a patient must need intensive rehabilitation under the supervision and medical management of a trained and experienced rehabilitation physician. Roughly 40% of patients referred to IRFs are not admitted because they do not meet the strict eligibility requirements.

The error rates CMS cites as justification for the RCD are not believable and are due to subjective decisions made by non-physicians who don't understand medical rehabilitation.

CMS has for years contracted with non-physician auditors to review the IRF admission decisions of rehabilitation physicians. In recent years, auditors have targeted for denial specific categories of patients, including people in need of rehabilitation after a stroke or extreme debility. Simply put, the error rates that CMS cites as justification for the RCD are not believable because CMS' auditors are unqualified and simply do not understand the service patients are receiving.

CMS and the Office of Inspector General (OIG) have spun these medical necessity disagreements into a vague allegation of fraudulent activity without citing one instance of an IRF fraudulently submitting a claim to Medicare. CMS' assertions that high IRF "error rates" justify this expansive demonstration lack credibility. IRFs routinely report reversal rates as high as 80% when denials are heard before neutral Administrative Law Judges.

The alleged error rates have also varied wildly, further casting doubt on their accuracy.

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CMS' previous use of Review Choice Demonstrations (RCDs) has been highly effective at reducing improper spending.

In the past, CMS has successfully used these types of demonstrations to reduce improper payments in areas with well-documented problems or other evidence of potential fraud – for example, where the utilization of particular benefits has abnormally spiked without justification.

CMS has previously applied these claims review demonstrations to help ensure the appropriateness of payments for home health care services; repetitive, scheduled non-emergency ambulance transport (RSNAT) services; selected hospital outpatient services; and certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), including power wheelchairs.

In areas where CMS has implemented a mandatory pre-claim review process in the past, suspect claims have dropped dramatically and often almost immediately saving Medicare significant funds. In 2018, the Government Accountability Office estimated that implementing RCDs in the four areas mentioned above saved Medicare between $1.1 and $1.9 billion over five years.[2]

RCD Authority is Based on Broad, and Well-Established Legal Authority.

The authority to conduct a focused anti-fraud initiative such as an RCD is well-established and based on broad statutory authority granted to HHS by Congress in 42 USC 1395b-1(a)(1)(J). That law states that the Secretary of HHS has the authority to "develop or demonstrate improved methods for the investigation and prosecution of fraud in the provision of care or services under the health programs established by the Social Security Act (the Act)." As the Secretary has done with the previous demonstrations noted above, he

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Although OIG alleged an 84% error rate in a sample of IRF claims from 2013, that same year, a CMS contractor estimated a 17% IRF overpayment rate, a five-fold difference. IRF error rates have fluctuated greatly despite no substantive changes in IRF regulatory requirements. This variation suggests a high level of subjectivity in these reviews and a fundamental lack of understanding of the complexity of IRF care by contract reviewers—the vast majority of whom are nurse reviewers, not physicians trained and experienced in rehabilitation medicine.

Further undercutting CMS' assertion, CMS reached a global settlement with IRF providers in 2019 to pay appealed IRF claims at 69% of the payable amount—the highest percentage of any recent global settlement. CMS also reimbursed certain denials at 100%, a tacit admission that these claims were wrongly denied in the first place.

This new policy will prevent thousands of patients from receiving care in a rehabilitation hospital – at a time when 40% of patients are already turned away due to strict eligibility requirements.

The RCD will harm thousands of patients. This 100% review by largely non-physician contract reviewers equates to CMS practicing medicine by delegating to these reviewers the authority to supersede the medical judgments of trained and experienced rehabilitation physicians. IRFs do not make admission decisions; treating physicians do. They admit patients in consultation with the rehabilitation team, referring physician, patient, and family. In fact, current regulations emphasize that the decision to admit a patient to an IRF is a complex medical judgment by the rehabilitation physician. The regulations do not create black-and-white coverage rules that can be applied mechanically by auditors.

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is simply using this broad authority again to initiate the IRF RCD.

The IRF-RCD is Not Overly Burdensome.

Importantly, the IRF RCD will not impose any new documentation requirements on providers. Instead, each provider's MAC will be reviewing documentation that Medicare already requires IRFs to complete and maintain in their patient records. IRFs will simply need to remit that existing information to their MAC for review.

And CMS is giving IRFs subject to this new demonstration the choice of providing the required documentation in either a pre-claim review or a post-claim review process, so that they have options in how they participate. Moreover, the burden if there is one is limited and can be effectively eliminated once the IRF demonstrates its compliance with Medicare's requirements by achieving a 90% claim approval rate on only 10 initial claims.

The IRF-RCD Will Help Discourage Fraudulent Behaviors.

Finally, it should be noted the independent, non-partisan, Medicare Payment Advisory Commission (MedPAC) has also been critical of CMS's existing payment policies for IRFs and has repeatedly called for both payment reforms and greater oversight.

In March 2019, the commission noted that IRFs have among the highest Medicare margins of any provider group, and that these margins have been rising steadily since 2009.[3] While high margins alone are not indicative of fraud, they may well provide greater inducement for an unethical provider to submit an improper claim.
The initial, full claims review proposed by the RCD will provide an effective vehicle for reminding the IRF sector of Medicare's various coverage and documentation requirements and a unique opportunity for providers to

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Universal claim review of every patient admission in certain states will place treating physicians in the untenable position of either denying IRF admission to qualified patients or continuing to accept these patients and placing the IRFs in which they practice at serious financial risk if these claims are denied. In this way, the RCD will produce a "gatekeeper" effect for certain types of patients (e.g., stroke, debility) that will result in inappropriate denials of IRF admissions for potentially tens of thousands of Medicare beneficiaries over the five-year demonstration period.

CMS appears to be pursuing an "end-run" around its responsibility to demonstrate evidence and employ public notice and comment when proposing to curtail Medicare coverage by, in effect, outsourcing this function to its contractors to achieve the same result through widespread audits. There is little doubt that, over time, the RCD will restrict IRF coverage. In fact, that appears to be the ultimate goal of the RCD program.

CMS' use of extensive audits to mold the IRF benefit is not new. The Recovery Audit Contractor (RAC) demonstration program in 2007-2010 provides a roadmap for the disaster that stakeholders anticipate with the IRF-RCD. The California RAC targeted lower-extremity joint replacement patients. Other CMS contractors subsequently targeted the same types of patients and when the burden of systematically appealing these cases was too much for IRFs to endure, joint replacement patients in the aggregate lost access to IRF care. This coverage preclusion is not written down in any policy that a beneficiary can see. It is a de facto policy that CMS outsourced to its contractors to impose through aggressive audits.

This is why every IRF stakeholder organization strongly opposes the RCD and asked CMS to withdraw it. Patient organizations oppose the RCD because it will restrict access

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revisit, confirm and level-set their ongoing compliance and related educational processes.

Conclusion

For the reasons discussed above, the proposal by CMS to adopt a targeted Review Choice Demonstration for IRFs is a judicious and reasonable idea. It should be implemented, as proposed.

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[1] Department of Health and Human Services, FY2020 Agency Financial Report, 210-11, accessed at https://www.hhs.gov/sites/default/files/fy-2020-hhs-agency-financial-report.pdf

[2] Government Accountability Office, Report to the Committee on Finance, US Senate, Medicare: CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending, April 2018, page 12-13.

[3] Medicare Payment Advisory Commission, Report to Congress: Medicare Payment Policy, March 2019, page 270.

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to IRF care. The rehabilitation physician association opposes the RCD because it will force rehabilitation physicians to deny IRF admissions over their better medical judgment. IRFs oppose it because of the massive burden of 100% claim review which will take precious time away from patient care. And disability rights organizations oppose it because IRFs discharge three out of four patients to home and community settings, where people with disabilities naturally want to access care and live independently.

Conclusion

The RCD will bar the door to IRF care for certain patients that CMS contractors deem unworthy of intensive, coordinated, interdisciplinary rehabilitation coupled with medical management, over the objections of treating rehabilitation physicians. Before creating unwritten coverage rules through the RCD, the agency should meet with IRF stakeholders and have clinical discussions with treating IRF physicians to identify the factors that establish medical necessity and determine which Medicare beneficiaries meet the IRF coverage requirements.

ALLIANCE FOR RECOVERY CARE

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