Medicare Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS): Coverage Requirements Webinar

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Objectives

- IRF PPS Coverage Requirements for Payment
- IRF PPS Discharge and Special Considerations for Payment

IRF PPS Coverage Requirements

IRF PPS Statutory Requirements

- Section 1886(j) of the Social Security Act provides for the implementation of a per-discharge Prospective Payment System (PPS) for inpatient rehabilitation hospitals and inpatient rehabilitation units of hospitals (collectively referred to as IRFs).
- Information from the IRF Patient Assessment Instrument (IRF PAI) classifies patients into distinct groups based on clinical characteristics and expected resource needs.
- CMS updates IRF rates annually due to statutory requirements and economic considerations.

IRF Setting

- Provide **intensive rehabilitation therapy** in a resource-intensive hospital environment for:
  - Medicare patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, **require and can reasonably be expected** to benefit from an inpatient stay and an interdisciplinary approach to the delivery of rehabilitation care.
  - Medicare patients **must be able to fully participate** in, and benefit from, intensive rehabilitation therapy program prior to transfer from the referring hospital.

Who is covered in an IRF? (Reasonable and Necessary)*

1. Multiple therapy disciplines
   - The Medicare patient must require active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics) and one of the therapies must be either physical therapy or occupational therapy.
   - Patients who require treatment by only one therapy discipline do not need to be in an IRF.
2. Intensive rehabilitation therapy program
   - At least 3 hours per day at least 5 days per week, OR
   - An average of at least 15 hours per week within 7 consecutive calendar days – requires documentation in medical record.

*42 CFR 412.622

Who is covered in an IRF? (Reasonable and Necessary), cont'd.*

3. Ability to participate in therapy program
   - The Medicare patient must reasonably be expected to actively participate in, and benefit significantly from, an intensive rehabilitation therapy program at the time of admission.
   - Therapy treatments must begin within 36 hours from midnight of the day of IRF admission.

4. Rehabilitation physician supervision

5. Medicare patients who require an interdisciplinary team of medical professionals for their care

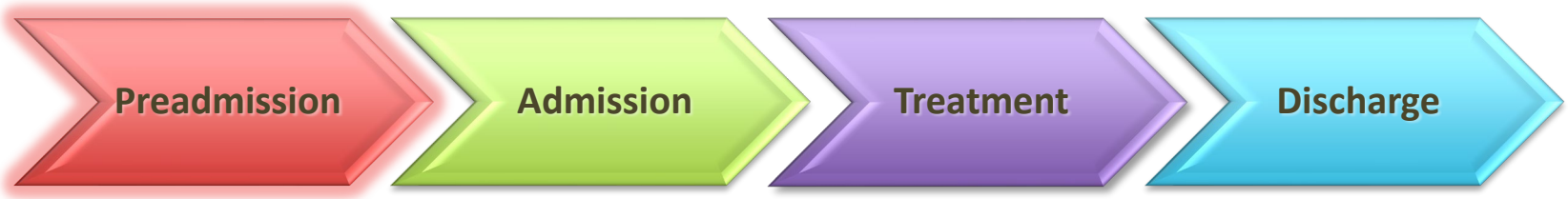
*42 CFR 412.622

Who is *not covered* in an IRF?

- Patients who have completed their course of treatment but do not require (or cannot actively participate in or benefit from) an intensive rehabilitation therapy program would **not be covered** in an IRF.

- IRF claims **will be denied** for patients who are still completing their course of treatment in the referring hospital and/or cannot tolerate an intensive therapy program.

IRF Patient Progression: Preadmission



Requirements of Preadmission Screening*

1. Timely
2. Comprehensive and Accurate Documentation
3. Document needs to stand alone and justify admission
    a. Supports the Admission Decision

*42 CFR 412.622 4(i)(A)(B)(C)

Timely Preadmission Screening

- Must be conducted within 48 hours immediately **preceding** the IRF admission OR

- If a comprehensive screening containing all the required elements was conducted **MORE THAN 48 hours** prior to admission, updated documentation of a preadmission screening must be included.

Preadmission Screening: Comprehensive and Accurate

- Conducted by a **licensed or certified clinician(s)** or rehabilitation physician.
  - Individual elements of the preadmission screening may be evaluated by any clinician or group of clinicians designated by the rehabilitation physician as long as the clinicians are licensed or certified to perform the evaluation.
    - Example: PT, OT, SLP, Rehabilitation nurse
- Conducted in person or by telephone through review of the patient's referring hospital medical records (if a hospital stay preceded the IRF admission).
- Includes a comprehensive review of the patient's condition/medical history.

Preadmission Screening: Comprehensive and Accurate Documentation that Stands Alone

Required Elements (per 42 CFR 412.622(a)(4)(i))**:**

- Level of function prior to the event
- Condition(s) that caused the need for rehabilitation
- Expected level of improvement and expected length of time to achieve that level of improvement
- Risk for clinical complications
- Combinations of treatments needed (PT, OT, Speech-language, or prosthetics/orthotics)
  - One therapy **MUST** be PT or OT (42 CFR 412.622(a)(3)(i))
- Anticipated discharge destination

Recommended elements:

- Expected frequency and duration of treatment in the IRF
- Anticipated post-discharge treatments
- Other information relevant to the patient's care needs

Preadmission Screening: Supports the Admission Decision

- Serves as the initial determination of whether or not the patient meets the requirements for an IRF admission to be considered **reasonable and necessary**.
- All preadmission screening documentation must be retained in the patient's medical record at the IRF and is subject to audit.
- The preadmission screening serves as the primary documentation by the IRF clinical staff of:
  - Patient's status prior to admission
  - Specific reasons that led the IRF clinical staff to conclude that the IRF admission would be reasonable and necessary

Should include detailed documentation/justification and can not be presented in the form of checkboxes

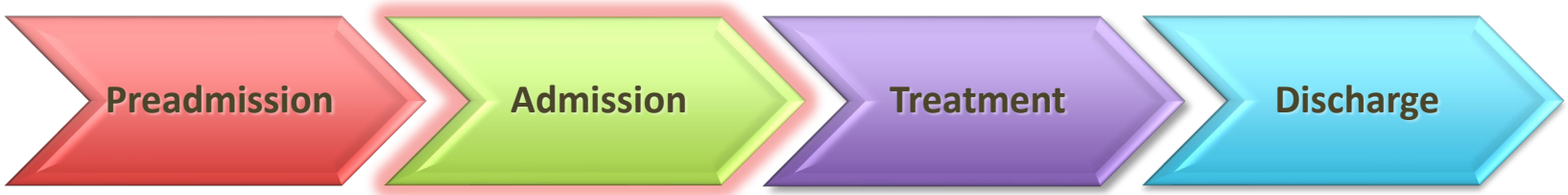
Preadmission Screening: Rehabilitation Physician's Role

- The Preadmission Screening is used to inform the rehabilitation physician, who must document his/her/their concurrence with the preadmission screening (as a whole) after the preadmission screening is complete and before the patient is admitted to the IRF.

Concurrence can <u>not</u> be delegated to a physician extender.

- The rehabilitation physician must indicate concurrence in one of the following ways:
  1. Signing/dating the original pre-admission screening document
  2. E-signing/dating pre-admission screening via closed electronic medical record system
  3. Signing/dating a copy of the document and faxing it to the IRF (for off-site reviews)

IRF Patient Progression: Admission to IRF



History and Physical Requirement

Effective in CMS' final FY 2021 IRF PPS rule, the full Post-Admission Physician Evaluation (PAPE) requirement is no longer required starting with discharges occurring on or after October 1, 2020 (85 FR 48424).

- While the PAPE requirement has been removed, the history and physical (H&P) is still required under the Conditions of Participation at 42 CFR § 482.24(c)(4)(i)(A).

Initiation of Therapy

- In accordance with 42 CFR § 412.622(a)(3)(ii), the required therapy treatments must begin **within 36 hours** from midnight of the day of admission to the IRF. Therapy evaluations are generally considered to constitute the beginning of the required therapy services.
  - Example: If admitted to IRF at 2pm on Tuesday, therapy treatments must be initiated by noon on Thursday (i.e., 36 hours after Tuesday at midnight)

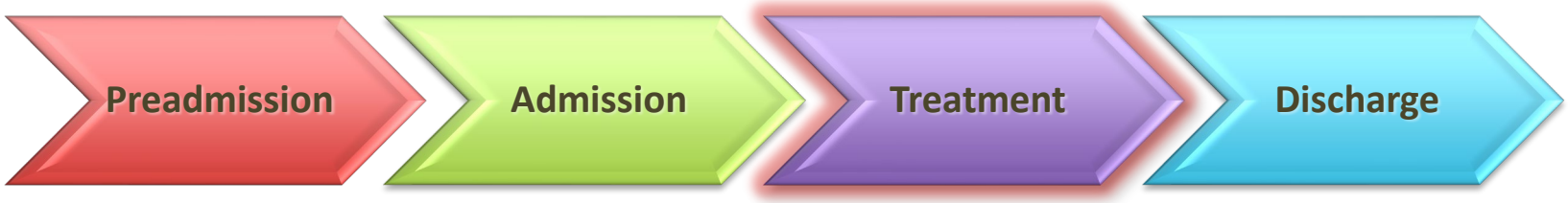
Individual Therapy is the Standard of Care

- The standard of care for IRF patients is **individualized, one-on-one therapy**.
- Therapy evaluations may constitute the initiation of therapy services for the purposes of demonstrating the intensity of therapy requirement.
- Intensity of therapy requirement is defined by one of the following therapies: Physical Therapy, Occupational Therapy, Speech Language Pathology or Prosthetics/Orthotics.
- Other therapy disciplines may be prescribed for and provided to Medicare beneficiaries, but they will be provided "above and beyond" the core required therapies.

What about group therapy?

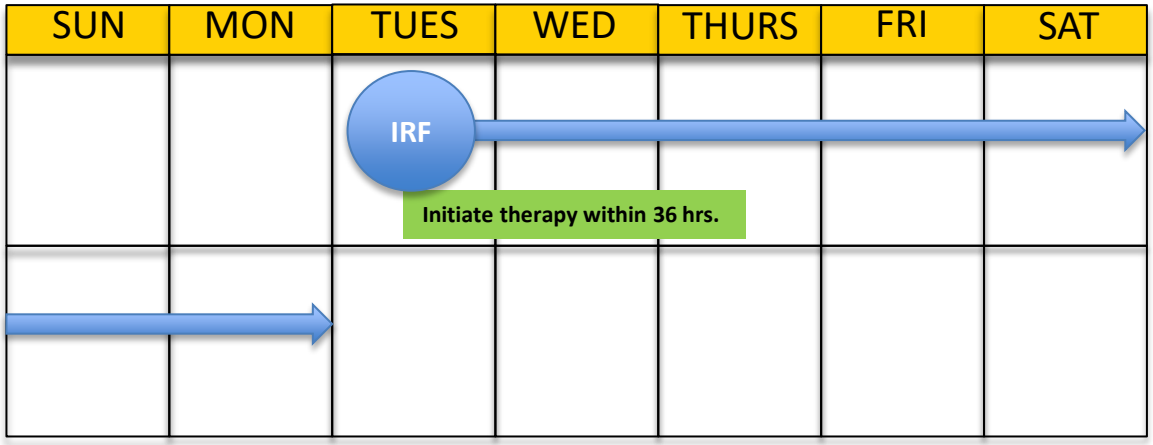
- Group therapies serve as an adjunct to individual therapies
- If group therapy better meets the patient's needs on a limited basis, the rationale should be well-documented in the patient's medical record.

IRF Patient Progression: Initiation of Treatment



Definition of a Week in an IRF

- Definition of a "**week**": any seven consecutive calendar days beginning with the date of the IRF admission.
    - Example: Admitted to IRF on Tuesday, one week (7 days) is through Monday. IRFs have 36 hours to initiate therapy treatments starting from midnight after IRF admission.*



*42 CFR § 412.622(a)(3)(ii)

Overall Plan of Care Requirements

- An individualized overall plan of care for the patient must meet the following requirements:*
  - Must be developed by the rehabilitation physician with input from the interdisciplinary team **within 4 days of admission** to the IRF (Day of IRF admission counts as Day 1).
  - Retained in the patient's IRF medical record.

*42 CFR § 412.622(a)(4)(ii)(A)&(B)

Overall Plan of Care

Suggested Elements:

- Individualized/Tailored to the unique care needs of the patient
- Estimated length of stay
- Medical prognosis
- Anticipated interventions, functional outcomes, and discharge destination
- Expected therapy:
  - Intensity by discipline (i.e., number of hours per day)
  - Frequency (i.e., number of days per week)
  - Duration (i.e., total number of days during the IRF stay)

Overall Plan of Care: IRF Reasonable and Necessary Criteria

A Medicare patient's Overall Plan of Care should reflect reasonable and necessary criteria:

- Treatment by multiple therapy disciplines
- Intensive rehabilitation therapy program
- Able to participate in therapy program
- Supervision by a rehabilitation physician
- Intensive and coordinated interdisciplinary team approach to rehabilitation

Requirements for the IRF-PAI

- The IRF-PAI provides key functional information and comorbidities of patients at IRF admission and discharge.

- The patient's IRF-PAI information should generally be included in the patient's medical record at the IRF (either in electronic or paper format).*

*42 CFR § 412.606(b); Note: This slide has been updated to reflect CMS guidance.

Requirements for the IRF-PAI, cont.

- The information contained on the IRF-PAI contributes to information for claims reimbursement. Specifically:
  - Impairment Group Code (IGC) (Item 21A); Note: CMS can no longer provide IGC coding assistance and recommends consultation with the treating physician or professional clinical coding experts.
  - Section GG and Bowel/Bladder items
  - Comorbidities

Need help?

- For IRF-PAI questions, please reference the IRF-PAI manual.
- For assistance with completing the IRF-PAI, please contact helpdesk@acumenllc.com.
- For technical issues related to the IRF-PAI, please contact: iqies@cms.hhs.gov.

Interdisciplinary Team Meeting Requirements

- The purpose of the interdisciplinary team meeting is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals.
- Team meetings must be held weekly and **MUST** focus on:
  - Review the individual's progress towards the stated rehabilitation goals.
  - Identify any problems that could impede progress towards those goals.
  - Reassess and/or modify previously established goals.
  - Revise the treatment plan if goals are modified/added.
  - Monitor continued progress toward those goals.

Interdisciplinary Team Meeting Requirements, cont.

- **Required Interdisciplinary Team Meeting Participants:**
  - A rehabilitation physician with specialized training and experience in rehabilitation services must lead the meetings.
    - May attend/lead the meeting virtually with the expectation that all other team members MUST attend in-person
  - A registered nurse with specialized training or experience in rehabilitation
  - A social worker or a case manager (or both)
  - A licensed or certified therapist from each therapy discipline involved in evaluating and treating the patient (i.e., not a therapy assistant)

Face-to-Face Visit Requirements

- The requirement for medical supervision is demonstrated by face-to-face visits.
- The rehabilitation physician must conduct in-person face-to-face visits at least 3 days per week throughout the Medicare patient's stay in the IRF.

1st Week of IRF Stay

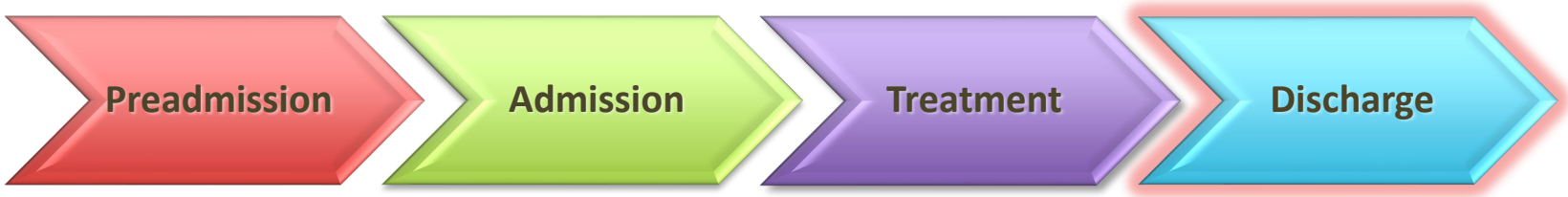
- **Only** the rehabilitation physician may conduct the three (3) face-to face visits.

2nd Week+ of IRF Stay

- **One of the three visits** each week can be conducted by a non-physician practitioner (NPP).
- The remaining two (2) visits each week must be conducted by the rehabilitation physician.

Discharge and Special Considerations for Payment

IRF Patient Progression: Discharge from IRF



IRF PPS Claims Reimbursement after Discharge

- A Medicare patient's admission data from the IRF-PAI (Impairment Group Code, age, functional status, comorbidities) classify them into a distinct case-mix group (CMG), comorbidity tier, and rehabilitation impairment category (RIC) based on their clinical characteristics and expected resource needs.

- An IRF grouper code (e.g., A0104) is generated from the combination of a patient's CMG, tier, and RIC and fed into the IRF claim.

- Each patient's "code" has a standard CMG payment that is adjusted by wage index, facility-level adjustments, and outlier payments before final claims reimbursement.

IRF PPS Special Considerations for Payment

- Brief Exceptions Policy
- Interrupted Stay Policy
- Short Stay Transfer Policy

Intensive Rehabilitation Therapy: Brief Exceptions Policy

- Contractors are authorized to grant brief exceptions (not to exceed 3 consecutive days) to the intensity of therapy requirement for **unexpected** clinical events or unplanned medical procedures.
  - CMS recommends 'missed' therapy time during the first 3 days of the IRF admission be made up to meet the intensive rehabilitation admission requirements.*

*Note: This slide has been updated to reflect CMS guidance.

Reasons for the brief exception to the intensity of therapy requirement must be well-documented in the patient's medical record at the IRF.

Intensive Rehabilitation Therapy: Brief Exceptions Policy - Examples

Examples of unexpected clinical events or unplanned procedures:

- Extensive diagnostic tests off premises
- Prolonged intravenous infusion of chemotherapy or blood products
- Bed rest due to signs of deep vein thrombosis
- Exhaustion due to recent ambulance transportation
- Unplanned surgical procedures

Interrupted Stay

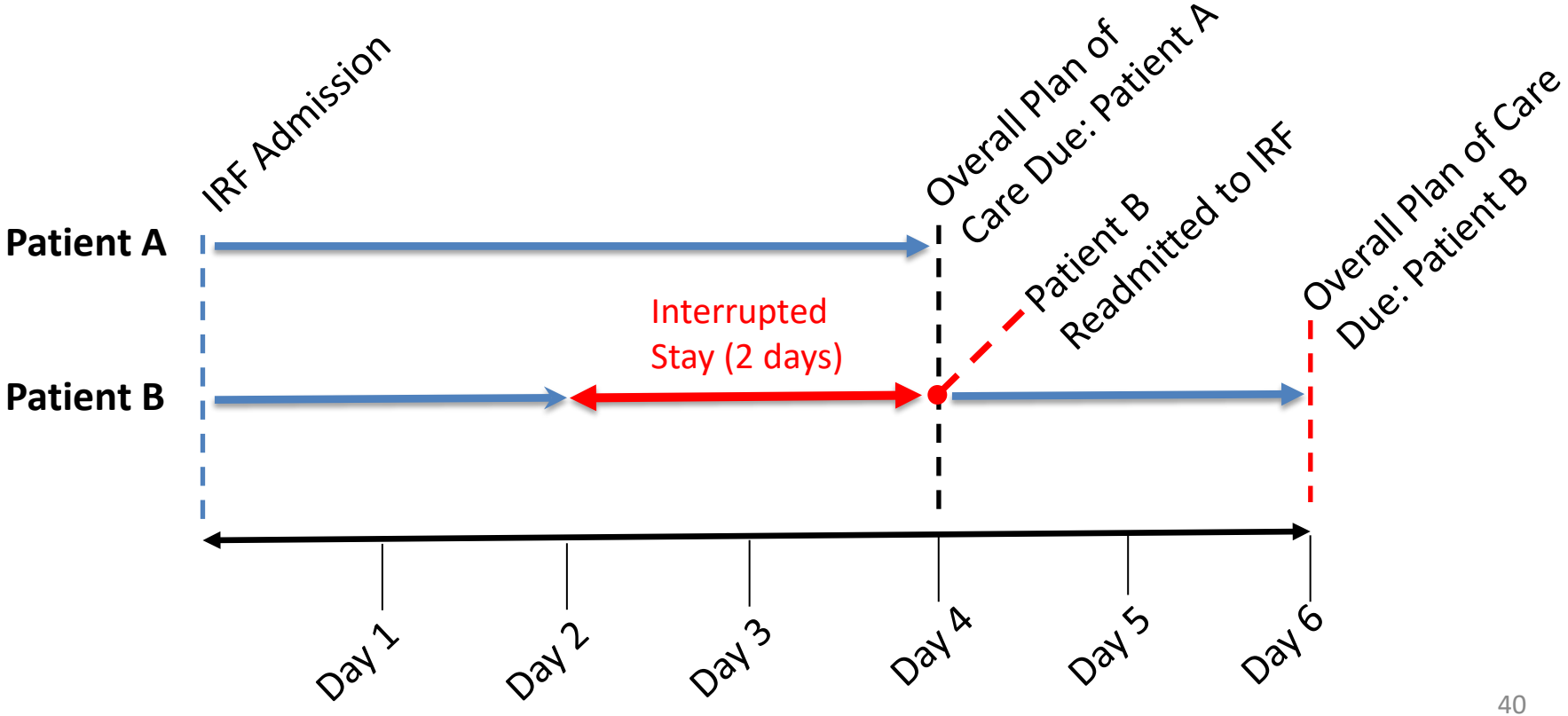
- An **interrupted stay** occurs when a patient is discharged from the IRF and returns to the IRF by midnight of the 3rd calendar day.
  - The IRF can only submit one combined claim to Medicare for an interrupted stay and only one CMG payment will be made for the entire/combined stay.
  - An IRF is NOT required to repeat preadmission screening and other required documentation. Updates to the patient's medical record should be made to reflect the patient's current condition, comorbidities, rehabilitation goals, plan of care, etc., if changed.
- If the patient returns **after midnight** of the 3rd calendar day, (i.e., 4 or more consecutive days), their new stay is treated as a second IRF stay and the IRF may bill for both stays separately. The required admission documentation must be completed as with any "new" IRF patient.

Interrupted Stay & Impact to Overall Plan of Care Timing

- Typically, the Overall Plan of Care must be completed by the Rehabilitation Physician within **4 days** of admission to the IRF.

- However, if a patient is out of an IRF in an interrupted stay situation, the days the patient is “out” will not be counted toward the 4-day requirement for when the overall plan of care is due. IRFs should strive to complete the overall plan of care as early in the IRF stay as possible to ensure the best outcome for the patient.

Interrupted Stay & Overall Plan of Care Timing: Example



Short Stay Transfer

- **Short stay transfer:** when a patient is in the IRF for less than the average length of stay for the case-mix group (CMG)/tier and is transferred to another institutional setting of care (e.g., another IRF, an inpatient hospital, a skilled nursing facility or nursing home that accepts payments under Medicare or Medicaid, or a long-term care hospital).

- **How does CMS determine reimbursement if a short stay transfer occurs?**
  - If a short stay transfer occurs, the amount of payment for the claim is a reduced per diem amount for each CMG/tier.

Resources & Questions (time permitting)

- Inpatient Rehabilitation Facility PPS | CMS
- IRF PPS Coverage Requirements
- Medicare Benefit Policy Manual
- IRF-PAI:
  - IRF-PAI Manual
  - IRF-PAI help desk: iqies@cms.hhs.gov
  - PAC training on completing the IRF-PAI

Further Questions? Please email questions to: IRFCoverage@cms.hhs.gov

Acronyms

- CMS: Centers for Medicare and Medicaid Services
- CY: Calendar Year
- CMG: Case Mix Group
- H&P: History and Physical
- IGC: Impairment Group Code
- IRF-PAI: Inpatient Rehabilitation Facility – Patient Assessment Instrument
- IRF PPS: Inpatient Rehabilitation Facility Prospective Payment System
- NPP: Non-Physician Practitioner
- OT: Occupational Therapy
- PAPE: Post-Admission Physician Evaluation
- PT: Physical Therapy
- RIC: Rehabilitation Impairment Group Code