

## **Follow-up information from the November 12 provider training call**

1. Clarification regarding the brief exceptions policy.

The new IRF coverage requirements permit Medicare’s contractors to grant brief exceptions (not to exceed 3 consecutive calendar days) to the intensity of therapy requirements for unexpected clinical events that limit a patient’s ability to participate in therapy for a limited number of days. For example, if a patient’s plan of care for a particular week calls for the patient to receive a specified number of hours of therapy on Monday, Tuesday, Wednesday, Thursday, and Friday of that week, but the patient experiences an unexpected clinical event on Sunday night that limits the patient’s ability to participate in therapy on Monday and Tuesday, Medicare’s contractors are authorized to allow a brief break in the provision of therapy services on Monday and Tuesday of that week, as long as the reasons for the break in therapy are well-documented in the patient’s medical record at the IRF. Since the provision of therapies on Saturday and Sunday were not part of this particular patient’s plan of care for that week, this example would illustrate a 2 day break in the provision of the patient’s intensive rehabilitation therapy program.

Under no circumstances may the IRF adjust a patient’s therapy plan to facilitate scheduling of the IRF staff or for the convenience of the staff. Also, the brief exceptions policy does not apply to the first 3 days of the patient’s admission to the IRF.

2. Clarification regarding the reasons for the short-stay payment (for IRF stays of 3 days or less) when a patient is determined, on admission, to no longer meet the requirements for admission to an IRF.

Generally, Medicare claims for patients who do not meet the criteria for admission to an IRF will be denied. However, we recognize that, even with a comprehensive and diligent preadmission screening, unexpected events happen which may result in the very rare case of a patient who is not appropriate for IRF care being inadvertently admitted to an IRF. This could happen, for example, if the patient experiences a severe clinical event between the preadmission screening and the patient’s admission to the IRF (such as a fall, cardiac arrest, or other sudden, unexpected event) that significantly changes the patient’s condition on admission to the IRF. Since there would be no way that the IRF could anticipate or prevent these issues from occurring, we have provided for the IRF to receive the short-stay payment (for IRF stays of 3 days or less) for patients admitted to the IRF under these conditions.

3. Clarification regarding the medical needs that warrant “medical necessity”?

Instead of using the term “medical necessity,” CMS now refers to appropriate IRF admissions as being “reasonable and necessary.” Thus, the new IRF coverage requirements in the regulations and in section 110 of the Medicare Benefit Policy

Manual (Pub. 100-02) define the criteria for an IRF admission to be considered reasonable and necessary.

4. Clarification regarding whether a patient referred from a skilled nursing facility or other similar type of facility can be considered an “approved” IRF admission.

Whether a patient comes to the IRF from an acute care hospital, a critical access hospital, a skilled nursing facility, or any other type of facility, the patient will be considered an “approved” IRF admission as long as he or she meets all of the IRF coverage requirements.

5. Clarification of the terms “significant benefit,” “measurable improvement,” “predetermined and reasonable period of time,” and “nature and degree of expected improvement.”

We believe that rehabilitation physicians are typically able to determine from examining a patient what represents “significant benefit” for that patient, what represents “measurable improvement” for that patient, what is a “reasonable period of time” to achieve the expected level of improvement, and what the “nature and degree” of that expected improvement would be. We also expect that the rehabilitation physicians will be able to clearly explain their reasoning in the patient’s overall plan of care, which must be documented in the patient’s medical record at the IRF.

6. Clarification regarding the provision of therapies on the day of discharge.

Generally, we do not expect patients to receive intensive therapies on the day of discharge from the IRF. However, the IRF may provide therapy on the day of discharge if the IRF believes that this is appropriate for the patient.

7. Clarification regarding how to demonstrate the intensity of therapy requirement for patients who are discharged within 7 days after admission to the IRF (or are in the IRF longer than 7 days but are discharged mid-term in their plan of care).

IRFs must document in patients’ medical records at the IRF that patients are receiving the appropriate intensive rehabilitation therapy program in the IRF up until the day of discharge. We expect that patients who are admitted for a planned short-stay would begin their intensive rehabilitation therapy program immediately after admission and continue it up to the day of discharge (and possibly including the day of discharge) to best respond to their medical and functional needs, though providing therapy on the day of discharge is not required. We will monitor patterns of short-stay admissions.

8. Clarification regarding whether patients who cannot tolerate the intensive rehabilitation therapy program can still be admitted to an IRF if an IRF admission is the only way that they can participate in a less intensive rehabilitation therapy program (i.e., if “lower tolerance” patients can still be admitted to an IRF).

No. Patients who cannot participate in and benefit from the intensive rehabilitation therapy program provided in an IRF can receive needed rehabilitation therapy services in other settings. Under the new coverage requirements, patients admitted to IRFs are expected to require, participate in, and benefit significantly from the intensive rehabilitation therapy program provided in an IRF.

9. Clarification on the definition of “actively participate” as used in the final rule.

By “active participation” in the intensive rehabilitation therapy program, we mean that a patient’s condition must be such that he or she can safely tolerate the level of rehabilitation therapy program provided in an IRF. Also, the intensity of therapy provided in the IRF must further the patient’s progress in meeting his or her functional goals, rather than setting the patient back in those goals by overtaxing him or her.

10. Clarification on whether or not the time from the family conference involving the patient, family members, and all active team members (physical therapy, occupational therapy, speech-language pathology, social work, and nursing) counts towards documenting the intensity of therapy requirement.

The time spent in family conferences does not count towards demonstrating the intensity of therapy requirement.

11. Clarification regarding whether patients can gradually build up to being able to participate in the intensive rehabilitation therapy program in the IRF.

No. Under the new requirements, the IRF must have a reasonable expectation that the patient will be able to participate in and benefit from an intensive rehabilitation therapy program upon admission to the IRF. While a plan of care may be customized during the course of an IRF stay to reflect changes in treatment needs, patients must continue to require and benefit from an intensive rehabilitation therapy program throughout the IRF stay. Patients who are still building up to being able to receive this intensive level of therapy must remain in the referring hospital setting (or another setting of care) until they are able to participate in and benefit from the intensive rehabilitation therapy program.

12. Clarification regarding whether a patient who receives a less-intensive rehabilitation therapy program on a particular day (due to a diagnostic test, for example) can make it up on another day.

The new coverage requirements include a brief exceptions policy (see clarification #1) that would apply to a patient who unexpectedly becomes ill or requires diagnostic testing on a particular day. The brief exceptions policy extends to patients who are unable to tolerate therapy for medical reasons for up to 3 consecutive calendar days during the patient’s stay in the IRF. Thus, if the reason for the patient to receive a

lesser amount of therapy or no therapy for up to 3 consecutive calendar days due to diagnostic testing or another medical reason is well-documented in the patient's medical record at the IRF, then this therapy would not need to be "made up" on another day.

However, the patient may make up the therapy on another day if the IRF believes that the patient can safely participate in and benefit from the additional therapy. For example, if the IRF knows that the patient is going to receive diagnostic testing on a Wednesday that will limit the patient's participation in therapy that day, the IRF can provide an additional hour of therapy on the Tuesday before or the Thursday after to make up for the missed time on Wednesday. Note, however, that the patient must be able to safely participate in and benefit from the additional therapy.

Under no circumstances may the IRF adjust a patient's therapy plan to facilitate scheduling of the IRF staff or for the convenience of the staff.

13. Clarification regarding what to do if a patient progresses so quickly that he or she does not receive the required amount of therapy prior to discharge.

If a patient has progressed more quickly than expected in his or her intensive rehabilitation therapy program, to the point that he or she no longer requires the intensive rehabilitation therapy program provided in an IRF, then the IRF should prepare to discharge the patient.

14. Clarification regarding whether there is any leeway in the 24 hour requirement for the post-admission physician evaluation to account for 1) a delay in the patient's transfer to the IRF, 2) a delay in the physician's dictation of his or her evaluation, 3) the physician's need to attend to another patient who needs immediate medical attention, or 4) delays due to weather or traffic, etc.

The regulations require the post-admission physician evaluation to be completed within 24 hours of the patient's admission to the IRF. In the case of extraordinary events, such as natural disasters or other states of emergency, that are beyond the control of the IRF, we would consider the appropriateness of using established mechanisms for waiving or modifying certain Medicare requirements such as section 1135 of the Social Security Act (under which the Secretary of Health and Human Services might permit a temporary modification of the timeline during the "emergency period" under section 1135(g)(1) of the Social Security Act).

15. Clarification regarding whether 1 therapy discipline performing a therapy evaluation within 36 hours from midnight of the day of admission would satisfy the initiation of therapy requirement and whether, if therapy evaluations are performed within this timeframe, therapy treatments must also begin within this timeframe.

Though we believe that it would be good practice for all of the therapy disciplines to initiate therapy services (at a minimum, conduct therapy evaluations) within 36 hours

from midnight of the day of a patient's admission to an IRF, this is not required. One therapy discipline conducting evaluations of the patient during this time period would technically satisfy the requirement, as long as the patient receives his or her intensive rehabilitation therapy program on that day.

For IRF care to be reasonable and necessary, the patient must require treatment from multiple therapy disciplines, and the patient must reasonably be expected to require, participate in, and benefit significantly from the intensive rehabilitation therapy program provided in the IRF on admission. This means that, at least by 36 hours from midnight of the day of admission but preferably as soon as the patient is admitted to the IRF, the patient will begin receiving his or her intensive rehabilitation therapy program.

16. Clarification regarding what it means that a patient's full course of treatment must be completed in the referring hospital prior to transfer to the IRF and what types of conditions can be safely managed in the IRF.

A patient's full course of treatment in the referring hospital has been completed and the patient can appropriately be transferred to the IRF once the patient's medical condition can be safely managed in the IRF *at the same time* that the patient is fully participating in and benefiting from the intensive rehabilitation therapy program provided in the IRF. The types of conditions that could be safely managed in an IRF may vary somewhat from one IRF to the next. However, the patient's condition must be such that he or she can safely perform the intensive rehabilitation therapy program provided in the IRF.

17. Clarification regarding whether an IRF must discharge a patient who, on admission, was believed to be able to tolerate the intensive rehabilitation therapy program provided in the IRF, but initially cannot fully participate in the intensive therapy program.

If, after admission, it is evident that the patient cannot tolerate the intensive rehabilitation therapy program provided in the IRF, then the IRF needs to begin the process of discharging the patient. Please note that the brief exception policy does not apply to the first 3 days of the patient's IRF stay.

18. Clarification regarding whether the requirement for "weekly" interdisciplinary team meetings can be met with a standing weekly meeting (for example, 2:00 pm every Wednesday).

Yes. One standing weekly interdisciplinary team meeting (for example, 2:00 pm every Wednesday) would satisfy the requirement for interdisciplinary team meetings to be held at least once per week throughout a patient's stay in the IRF.