Follow-up information from the November 12 provider training call

I. Admission Orders

1. Clarification regarding whether an admission order must be completed before any therapy evaluations are initiated.

Answer: Yes. Consistent with the hospital conditions of participation in 42 Code of Federal Regulations (CFR) 482.12 and current standards of practice, admission orders must be completed prior to any rehabilitation therapy services being provided to patients.

2. Clarification as to what should be included in the admission order.

Answer: The new IRF coverage guidelines did not substantively change the requirements for the admission order. However, an admission order should generally guide the overall care of the patient and should include any specific treatments that need to be administered to the patient.

3. Clarification regarding whether a physician extender (such as a nurse practitioner or a physician assistant) or medical resident can generate the admission orders. (Note that this is an update to a previous clarification.)

Answer: In accordance with State law and hospital policy, a physician extender or medical resident, working in collaboration with the physician, may generate the admission orders.

II. Preadmission Screening

4. Clarification regarding who performs the update at the acute care facility in instances when the preadmission screening is conducted more than 48 hours immediately preceding the IRF admission.

Answer: It is the responsibility of each IRF to develop procedures to collect accurate information on which to base admission decisions. We would expect that IRFs would develop protocols with the acute care hospitals in their service areas to manage the collection of information for updating the preadmission screening when the comprehensive preadmission screening is conducted more than 48 hours immediately preceding the IRF admission.

5. Clarification regarding whether a certified occupational therapy assistant or a physical therapy assistant can contribute to an initial evaluation and perform assessments.

Answer: Generally, current State licensure laws preclude therapy assistants from furnishing evaluation or assessment services. A therapy assistant may perform objective tests or measurements or make observations of fact, which they would then report to the therapist. Therapists may then use that information when making the clinical judgments and planning decisions required for evaluation and assessments.

6. Clarification regarding out-of-state licensure of the clinician(s) conducting the preadmission screening.

Answer: It is the responsibility of the IRF and the rehabilitation physician to ensure that the personnel conducting the preadmission screening have the necessary training and qualifications to practice in the required geographic area.

7. Clarification regarding whether an abbreviated "short form" version of the preadmission screening could be done on weekends.

Answer: No, a "short form" version of the preadmission screening will not meet the documentation requirements. A comprehensive preadmission screening must be performed on all Medicare patients admitted to an IRF.

8. Clarification as to the process for documenting in the preadmission screening that a patient is not an appropriate candidate for IRF (that is, whether the rehabilitation physician needs to document concurrence with the decision not to admit the patient to the IRF).

Answer: We do not require any specific documentation of the decision not to admit a patient to an IRF because the case is not billable to Medicare. However, we would expect that each IRF would develop policies regarding documentation of the clinical decision not to admit a patient to the IRF as well as the means to notify the referring facility.

9. Clarification as to whether, if the comprehensive preadmission screening is conducted more than 48 hours prior to the IRF admission, the required update of the preadmission screening needs to include both the medical and functional status of the patient.

Answer: The preadmission screening must contain comprehensive documentation of the physician's decision-making process for the admission of each individual patient. Thus, if there are any changes in the patient's medical status, functional status, or any other aspects of the patient that would affect the physician's decision-making process between the comprehensive preadmission screening and the update, then the update must include detailed information on these changes. A change in functional status, for example, may indicate either an exacerbation or improvement of the individual's general condition and may affect the overall evaluation of the patient's need for rehabilitation therapy.

Fundamentally, it is the responsibility of the IRF to ensure that the rehabilitation physician has the most current and complete information on which to base the IRF admission decision. If the information is not current and complete, and as a result the patient is admitted inappropriately, then the IRF claim will be denied.

10. Clarification regarding whether an IRF claim could be denied because a preadmission screening contains missing or conflicting information.

Answer: We expect that IRFs would make every effort possible to include the basic information that we are requesting in the medical record so that medical reviewers can determine the appropriateness of the admission. The information should sufficiently describe the services furnished and the medical need for these services. If missing or conflicting information is not reasonably explained in the appropriate document in the IRF medical record, then the IRF claim could be subject to denial.

11. Clarification regarding whether the IRF needs to complete a new preadmission screening and other required documentation as if the patient were a "new" patient when a patient is discharged from the IRF, admitted to the acute care hospital for medical reasons, and returns to the IRF by the end of the 3rd day (that is, an IRF interrupted stay).

Answer: CMS considers an IRF interrupted stay to be one combined IRF stay. Therefore, the IRF would not be required to repeat all of the required documentation when the patient returns to the IRF after the interruption. However, we would expect the IRF to update the information in the patient's medical record to ensure that it is current (that is, update the patient's condition, comorbidities, rehabilitation goals, plan of care, etc.). In addition, the patient must continue to meet the criteria for admission to an IRF (the need and benefit from the intensive rehabilitation therapy program, the need for multiple therapy disciplines, etc.), and all of the elements required during the patient's stay (the 3 physician visits per week, the weekly interdisciplinary team meetings, etc.) must be provided.

If the patient returns to the IRF in 4 or more consecutive days (that is, it is not considered an interrupted stay), then all of the required documentation must be completed as with any "new" IRF patient.

12. Clarification regarding what preadmission screening functions must be performed by a licensed or certified clinician and what tasks may be performed by non-clinical personnel.

Answer: The act of reviewing and selecting what information to record on the preadmission screening form is clinical in nature and needs to be performed by a licensed or certified clinician who is appropriately trained and qualified to assess the patient's medical and functional status, assess the risk for clinical and rehabilitation complications, and assess other aspects of the patient's condition both medically and functionally. Non-clinical personnel may perform non-clinical tasks (for example, copying and faxing the information).

13. Clarification regarding whether the licensed or certified clinician(s) conducting the preadmission screening can be employed by the discharging acute care hospital.

Answer: No.

14. Clarification regarding whether FIM™ certification meets the requirements for certification of the personnel who conduct the preadmission screening.

Answer: No.

III. Post-Admission Physician Evaluation

15. Clarification regarding whether the history and physical exam can be done by a physician affiliated with the acute care hospital, while the remaining portion of the post-admission physician evaluation is completed by the rehabilitation physician in the IRF.

Answer: The IRF admission documentation must be completed by IRF personnel and cannot be completed by personnel of the acute care hospital. The history and physical exam can be done by an appropriate IRF clinician, in accordance with State licensure laws and hospital policies. However, the rehabilitation physician is responsible for the post-admission physician evaluation, which documents the patient's status on admission to the IRF, identifies any relevant changes in the patient that have occurred since the preadmission screening, includes a review of the patient's prior and current medical and functional conditions and comorbidities, and serves as the basis for the development of the individualized overall plan of care. The information contained in the history and physical exam must clearly support the rest of the rehabilitation physician's conclusions that are documented in the post-admission physician evaluation.

16. Clarification regarding whether the post-admission physician evaluation must be completed on a weekend for a patient who is admitted to an IRF on a Friday.

Answer: Yes. If the patient is admitted to the IRF on Friday and the post-admission physician evaluation cannot be completed on Friday, then it must be completed on Saturday.

17. Clarification regarding whether therapy evaluations/treatments may be provided in the IRF prior to the physician completing the post-admission physician evaluation.

Answer: Yes. Therapy treatments (including therapy evaluations) may begin before the post-admission physician evaluation is completed. However, as mentioned previously, therapy treatments (including therapy evaluations) may not begin before IRF admission orders are signed.

18. Clarification regarding whether an IRF claim may be subject to denial if the post-admission physician evaluation was not completed within the 24 hours immediately following the IRF admission, even though the patient's medical and functional status appeared to warrant an IRF admission.

Answer: Yes, an IRF claim is subject to denial if the documentation requirements are not met. However, we expect that IRFs would make every effort possible to include the basic information that we are requesting in the medical record so that medical reviewers can determine the appropriateness of the IRF admission.

19. Clarification regarding whether Advance Practice Nurses, physician's assistants, certified nurse practitioners, or medical residents can assist the rehabilitation physician with orders, admission notes, the history and physical, daily progress notes, the post-admission physician evaluation, or the minimum 3 face-to-face physician visits per week.

Answer: The usual Medicare regulations regarding the use of physician extenders and medical residents in providing services to Medicare beneficiaries apply to the completion of the history and physical, admission orders, and routine chart notes. Thus, these tasks can be completed by an appropriate IRF clinician, in accordance with State licensure laws and hospital policies.

However, the rehabilitation physician is responsible for examining the patient and completing the post-admission physician evaluation, which documents the patient's status on admission to the IRF, identifies any relevant changes in the patient that have occurred since the preadmission screening, includes a review of the patient's prior and current medical and functional conditions and comorbidities, and serves as the basis for the development of the individualized overall plan of care. The rehabilitation physician's examination of the patient must be adequate to establish the individual overall plan of care.

Further, the rehabilitation physician is responsible for conducting the minimum of 3 face-to-face physician visits per week for the purposes of assessing the patient both medically and functionally. This responsibility cannot be delegated to anyone other than another rehabilitation physician.

IV. Three Physician Visits

20. Clarification regarding whether the rehabilitation physician's interdisciplinary team conference note can serve as one of the minimum required 3 rehabilitation physician face-to-face visits per week.

Answer: No. The new IRF coverage requirements specify that there must be documentation of weekly interdisciplinary team meetings throughout the patient's stay in the IRF and separate

documentation of at least 3 face-to-face rehabilitation physician visits per week for the purpose of assessing the patient both medically and functionally. These requirements cannot be combined.

V. Interdisciplinary Team Meetings

21. Clarification regarding the weekly interdisciplinary team meeting requirement.

Answer: According to the new IRF coverage requirements, interdisciplinary team meetings must occur at least weekly throughout a patient's stay in the IRF. This generally means that one meeting must be held every 7 days throughout the patient's stay in the IRF. However, CMS has issued clarifications on the Web site at http://www.cms.gov/InpatientRehabFacPPS/04_Coverage.asp#TopOfPage that one standing weekly interdisciplinary team meeting generally meets this requirement. Thus, for example, if the IRF's weekly standing interdisciplinary team meeting is every Wednesday at 2:00 pm, then patients admitted to the IRF on Wednesday at 5:00 pm (after the regularly-scheduled weekly team meeting) may have their first weekly interdisciplinary team meeting the following Wednesday at 2:00 pm (technically the 8th day of the patient's stay in the IRF).

We note that all patients who are in the IRF at the time of the weekly standing interdisciplinary team meeting must be discussed at that meeting. Thus, for example, it is not acceptable for patients to be discussed for the first time at the interdisciplinary team meeting on the 9th or 10th day of their stay.

If, at some point, the IRF moves the standing weekly team meetings to another day of the week (for example, to Thursdays at 2:00 pm instead of Wednesdays at 2:00 pm), then the IRF should hold an extra "interim" interdisciplinary team meeting sometime before the change occurs to ensure that the weekly interdisciplinary team meeting requirement continues to be met for each patient.

22. Clarification regarding whether a physician's assistant, certified nurse practitioner, or medical resident can lead the interdisciplinary team meetings under the direction of the rehabilitation physician.

Answer: No. The documentation in the IRF medical record must clearly demonstrate that the rehabilitation physician led the interdisciplinary team meetings.

23. Clarification regarding whether the rehabilitation physician can occasionally participate in the interdisciplinary team meetings by telephone.

Answer: As long as it is clearly demonstrated in the documentation in the IRF medical record that the rehabilitation physician was leading the interdisciplinary team meeting, he or she may

conduct the meeting by telephone. We understand that it may occasionally be difficult for the rehabilitation physician to be physically present in the meetings. The specific reasons that the rehabilitation physician led the interdisciplinary team meeting by telephone rather than in person must be well-documented in the patient's medical record at the IRF.

24. Clarification regarding the documentation of the rehabilitation physician's participation in the interdisciplinary team conference if the rehabilitation physician led the meeting via telephone from an offsite location.

Answer: It must be clear in the documentation that the rehabilitation physician led the interdisciplinary team meeting, as required in the regulation, even if the rehabilitation physician called into the meeting by telephone. One of the participants of the interdisciplinary team meeting must document in the IRF medical record that the rehabilitation physician led the team meeting by telephone and the reasons why. The rehabilitation physician must confirm this documentation in the IRF medical record when he or she returns to the IRF. In addition, the rehabilitation physician must document concurrence with all decisions made by the interdisciplinary team at the team meeting.

25. Clarification regarding whether other health care professionals (besides those specifically mentioned in the regulation) must attend the weekly interdisciplinary team meetings.

Answer: The weekly interdisciplinary team meetings are required to be led by a rehabilitation physician and to include a registered nurse with specialized training or experience in rehabilitation and a social worker or case manager or (both). In addition, the regulations require that a licensed or certified physical therapist, occupational therapist, and speech-language pathologist (to the extent that each of these particular disciplines is involved in the patient's care) participate in the weekly interdisciplinary team meetings. We believe that it is within the rehabilitation physician's discretion, in consultation with the patient's therapists and the other required interdisciplinary team members, to determine whether or not additional team members (for example, orthotists/prosthetists, psychologists/neuropsychologists, etc.) need to be at the interdisciplinary team meetings, on a patient-by-patient, meeting-by-meeting basis. If the patient is having some problems with his or her intensive rehabilitation therapy program that the additional disciplines could help solve, the rehabilitation physician might want to invite these disciplines to attend the meeting. However, it is not required.

If non-required specialties that are covered under the Medicare Quality Standards cannot be present at the weekly interdisciplinary team meetings, they must still perform their reporting duties as specified in the Medicare Quality Standards (available at http://www.cms.hhs.gov/medicareprovidersupenroll/downloads/dmeposaccreditationstandards.pdf).

26. Clarification regarding whether the social worker needs to be strictly devoted to rehabilitation as a required interdisciplinary team member in the IRF or whether the social worker's duties can also encompass acute care.

Answer: The new IRF coverage requirements are not intended to limit the scope of the social worker's duties within the hospital. It is up to the particular operations of the hospital how to divide the social worker's services between the IRF and his or her other duties.

27. Clarification regarding whether an interdisciplinary team conference is required for patients who are admitted to the IRF for fewer than 7 days.

Answer: Though it is good practice to discuss a patient's care in the IRF as often as possible throughout the patient's IRF stay, it is not technically required for the IRF to have an interdisciplinary team meeting for a patient who is in the facility fewer than 7 days. However, the IRF must demonstrate that it is providing the patient with adequate medical supervision. We will monitor patterns of short-stay admissions to determine that all IRF admission criteria are met.

28. Clarification regarding the meaning of the phrase "current knowledge of the patient" with respect to the required interdisciplinary participants at the weekly team meeting.

Answer: By "current knowledge of the patient", we mean an awareness of the patient's condition and a basic knowledge of the patient's medical and/or functional status and overall treatment plan at the time of the meeting. Each interdisciplinary team member must have current knowledge of the patient so that he or she can actively participate in the evaluation of the patient's progress toward his or her goals and the modification of the treatment plan so that it best contributes to future progress. This does not mean that the interdisciplinary team participant must be the same clinician who is responsible for the day-to-day documentation in the patient's medical record.

29. Clarification regarding the definition of a registered nurse with specialized training or experience in rehabilitation and whether FIM™ certification is sufficient to meet the requirement.

Answer: FIM™ certification does not meet the requirement of specialized training or experience in rehabilitation. Registered nurses do not require advanced certification (certified rehabilitation registered nurse (CRRN)), but they do require specialized training or experience in rehabilitation. It is the responsibility of each IRF to ensure that the rehabilitation nurses and physicians that are caring for patients and making treatment decisions are appropriately trained and qualified.

30. Clarification regarding whether a rehabilitation physician who is covering for a rehabilitation physician on vacation needs to attend the interdisciplinary team meeting.

Answer: Yes. The interdisciplinary team meeting must be led by a rehabilitation physician. Further, the covering rehabilitation physician must perform all functions as if he or she were the regularly assigned rehabilitation physician.

31. Clarification regarding whether the required social worker or case manager participating in the interdisciplinary team meeting needs to be licensed or certified and whether a registered nurse or licensed practical nurse can function in this role.

Answer: The practices of social work and nursing are defined in state law, and therefore vary by state. Further, professional specialties that perform case management services are guided by their specific regulatory requirements. It is the responsibility of the IRF and the rehabilitation physician to ensure that the personnel employed by the IRF have the necessary training and qualifications and that they perform their duties consistent with Federal and state law and regulations.

32. Clarification regarding whether it is acceptable for a licensed practical nurse or a licensed vocational nurse (instead of the registered nurse with specialized training or experience in rehabilitation) to represent the nursing discipline at the interdisciplinary team meetings.

Answer: No. The regulations require the nursing representative to be a registered nurse with specialized training or experience in rehabilitation.

33. Clarification regarding the independent role of medical students on internships in the new IRF coverage requirements.

Answer: Students are not recognized as official personnel; however, they may attend the interdisciplinary team meetings for educational purposes. Under current regulations, the independent documentation of students does not fulfill any IRF coverage requirements.

34. Clarification regarding the required documentation for the interdisciplinary team meetings.

Answer: The guidance provided in Chapter 1, section 110.2.5 of the Medicare Benefit Policy Manual (Pub. 100-02) regarding documentation of the interdisciplinary team meeting is the following:

> *"Documentation of each team conference must include the names and professional designations of the participants in the team conference. The occurrence of the team conferences and the decisions made during such*

conferences, such as those concerning discharge planning and the need for any adjustment in goals or in the prescribed treatment program, must be recorded in the patient's medical record in the IRF."

VI. Therapy

35. Clarification regarding whether the 36-hour requirement for the initiation of intensive rehabilitation therapies begins on the midnight prior to the IRF admission or the midnight after the IRF admission.

Answer: We mean the midnight after IRF admission. For example, for a patient admitted at 2:00 pm on Tuesday, the patient's intensive rehabilitation therapy program is required to start no later than Thursday at noon.

36. Clarification regarding the percentage of one-on-one individualized therapy that would constitute the "bulk" of therapy.

Answer: We expect the preponderance of therapy a patient receives at the IRF to be individualized, one-on-one therapy. IRF patients require an intensive and complex level of therapy services designed specifically to their individual needs. We believe that individualized, one-on-one therapy most appropriately meets the specialized needs of IRF patients.

We have not yet established a required percentage of one-on-one individualized therapy in the IRF setting because we are seeking more information on the amount of one-on-one versus group therapies that are most beneficial to patients. The specific benefit to the IRF patient of any group therapy that is provided must be well-documented in the IRF medical record.

37. Clarification regarding how much therapy must be provided to meet the requirement for the initiation of therapy within 36 hours from midnight of the day of admission to the IRF.

Answer: We expect the patient's full course of intensive rehabilitation therapy services, as described in the patient's overall plan of care, to be initiated within 36 hours from midnight of the day of admission to the IRF. Therapy evaluations count as the initiation of therapy services and may also be used to demonstrate the intensity of therapy services requirements. However, in many cases therapy treatment sessions must also be conducted in addition to therapy evaluations to fulfill the patient's full course of intensive rehabilitation therapy services, as described in the patient's overall plan of care. For example, if a patient is admitted to the IRF on a Friday and the patient's overall plan of care calls for the patient to receive at least 3 hours of therapy per day at least 5 days per week, then we would expect that the patient's intensive rehabilitation therapy program would be initiated no later than noon on Sunday, which would typically mean that the patient would receive at least 3 hours of therapy by noon on Sunday.

38. Clarification regarding the definition of "therapy time."

Answer: For purposes of demonstrating the intensity of therapy requirement, "therapy time" is time spent in direct contact with the patient. Time spent documenting in the patient's medical record, unsupervised modalities, and significant periods of rest are examples of time not spent in direct contact with the patient and, therefore, may not be used to demonstrate the intensity of therapy requirement.

39. Clarification regarding how the minutes for co-treatment count towards the intensive rehabilitation therapy requirement.

Answer: If the patient receives15 minutes of individualized therapy from an occupational therapist and 15 minutes of individualized therapy from a physical therapist, then the patient has received 30 minutes of intensive rehabilitation therapy. Co-treatment must be clinically appropriate and provided solely for the benefit of the patient. Co-treatment may not be used for the accommodation of staffing schedules. The specific benefit to the patient of the co-treatment must be well-documented in the IRF medical record.

40. Clarification regarding whether therapy treatments must be provided on consecutive days.

Answer: The patient's intensive rehabilitation therapy program does not have to be provided on consecutive days, as long as the patient's plan of care for the 7-day period is met.

41. Clarification regarding whether there must be a direct statement in the patient's IRF medical record indicating that the patient's intensive rehabilitation therapy program will be interrupted due to an unexpected clinical event that limits the patient's ability to participate in therapy for up to 3 consecutive days and, if so, who may document this.

Answer: Yes. The specific reasons for the break in the provision of intensive therapy services (not to exceed 3 consecutive days) must be well documented in the patient's IRF medical record by either a physician or a medical resident or physician extender, in accordance with State law and hospital policy.

42. Clarification regarding whether "missed" therapy minutes one day can be made up on another day within the same 7 consecutive day period starting with the day of admission.

Answer: Generally, yes. For example, if a patient receives his or her intensive rehabilitation therapy program Monday through Thursday, but then refuses to participate in the last 30 minutes of his or her intensive rehabilitation therapy program on Friday, then the additional 30 minutes of "missed" therapy time can be made up on either Saturday or Sunday. In no case can the "missed" therapy time be made up in a different week; it must be made up within the

same week (7 consecutive day period starting with the day of admission) that the "missed" time occurred. The reasons for the "missed" therapy time on Friday must be well documented in the patient's medical record at the IRF, and repeated refusals by the patient to participate in the intensive rehabilitation therapy program should prompt the interdisciplinary team to investigate further and consider discharging the patient to a more appropriate setting.

43. Clarification regarding the consequences of not providing therapy services in an IRF on weekends.

Answer: Failure to comply with all of the IRF coverage requirements may result in the IRF being out of compliance with governing regulations, which could potentially subject the IRF to declassification.

44. Clarification regarding whether whirlpool therapy can be used to demonstrate the intensity of therapy requirement in the IRF.

Answer: Whirlpool therapy may be beneficial to some IRF patients; however, to demonstrate that the treatment is intensive rehabilitation therapy, the IRF would need to provide a very well-documented clinical reason, evidence that supports the need for the service, the effectiveness of the intervention, and that the one-on-one treatment was appropriately performed.

45. Clarification regarding CMS's expectations with regard to the provision of therapies when a therapist is out sick.

Answer: Please see our responses above and in earlier clarifications regarding the various ways to demonstrate the intensity of therapy requirement. It is the responsibility of the IRF to provide adequate staffing coverage to deliver the appropriate services to IRF patients. It is standard practice for IRFs to plan for staff absences so that they can continue to execute patients' plans of care.

46. Clarification regarding CMS's expectations with regard to meeting the coverage requirements when extreme weather situations arise.

Answer: Generally, we expect the IRFs to plan for unusual but expected events, such as snowstorms, so that they can continue to provide patients with required services as specified in patients' plans of care. We have indicated in previous clarifications that IRFs may make up "missed" therapy time from one day on another day to ensure that patients receive their required intensive rehabilitation therapy program.

In addition, we have indicated in previous clarifications that, 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). This issue is also addressed in Chapter 3, section 3.8 of the Medicare Program Integrity Manual (Pub. 100-08).

47. Clarification regarding the use of SOAP notes and treatment flow sheets for demonstrating the intensity of therapy requirement.

Answer: Regardless of the type of documentation the IRF and the therapist choose to use, the IRF medical record must clearly demonstrate the types and amounts of therapies received by the patient and the reasons for the provision of the various types and amounts of therapy.

VII. Admissions

48. Clarification regarding the billing requirements when the patient's preadmission screening indicates that the patient is appropriate for IRF care but the post-admission physician evaluation shows that the patient is no longer appropriate for IRF care.

Answer: When the preadmission screening indicates that the patient is appropriate for IRF care but the post-admission physician evaluation shows that the patient is no longer appropriate for IRF care, the IRF must immediately begin the process of discharging the patient. If the IRF discharges the patient in 3 days or less, then the IRF is expected to bill the CMG that the facility receives from submitting the IRF patient assessment instrument (IRF-PAI), as usual. However, if it takes the IRF 4 or more days to discharge the patient, then the IRF must record the CMG (A5001) for IRF patient stays of 3 days or less. Note that the Medicare claims processing system will reject an IRF claim with A5001 if the length of stay is 3 days or less, since the IRF is only expected to bill A5001 if the patient stay is 4 days or more.

49. Clarification regarding whether the new IRF coverage requirements apply to Medicare Advantage, Medicare Secondary Payer, or Medicaid patients.

Answer: In 42 Code of Federal Regulations §412.622(4), it says that the new documentation requirements apply to any patient for whom the IRF seeks payment directly from fee-for-service or traditional Medicare. Since the Medicare Advantage companies reimburse IRFs for treatment of Medicare Advantage patients, the documentation requirements do not apply to Medicare Advantage patients (unless the Medicare Advantage companies adopt the same policies). Similarly, the Medicare coverage requirements do not apply to Medicaid patients, unless the State Medicaid program adopts the same policies. However, if the IRF is filing a claim and seeking any reimbursement directly from traditional Medicare for a Medicare Secondary Payer patient, then the Medicare fee-for-service IRF coverage requirements would apply to these patients.

50. Clarification regarding how the new coverage requirements affect referrals from home where the patient may not have had a recent acute care hospital stay.

Answer: The new IRF coverage requirements apply equally to all Medicare patients for whom the IRFs are seeking payment from Medicare, regardless of where they were prior to admission to the IRF. The only difference is that patients who did not have a prior acute care hospital stay will typically not have prior hospital records on which to base a preadmission screening, so the preadmission screening will typically have to be conducted in person in these situations.

51. Clarification regarding whether a patient's expected (or actual) discharge destination from the IRF will affect whether an IRF claim will be considered "reasonable and necessary".

Answer: No. IRF claims will not be denied based solely on the setting to which the patient is discharged at the end of the IRF stay. As we have indicated in Chapter 1, Section 110 of the Medicare Benefit Policy Manual (Pub. 100-02), "In general, the goal of IRF treatment is to enable the patient's safe return to the home or community-based environment upon discharge from the IRF." The phrase "[I]n general" is intended to indicate that this will not be the case in every instance.

52. Clarification regarding whether the new IRF coverage requirements will be published in the State Operations Manual.

Answer: No. Medicare coverage requirements for IRFs are not published in the State Operations Manual. IRF coverage requirements are found in the Medicare Benefit Policy Manual (Pub. 100-02).

53. Clarification regarding CMS's expectations if patients experience a significant change in condition that prevents them from participating in their intensive rehabilitation therapy program within the first 3 days of admission to the IRF, given that the brief exceptions policy cannot be applied to the first 3 days of the admission.

Answer: If the significant change in the patient's condition means that the patient is no longer appropriate for IRF care, the IRF must immediately begin the process of discharging the patient to a more appropriate setting of care. However, if the significant change in the patient's condition is expected to be temporary such that the patient will be able to resume their full course of treatment in the IRF for the 7 consecutive day period, then the "missed" therapy time can be made up on a subsequent day and the IRF stay may continue.

VIII. Individualized Overall Plan of Care

54. Clarification regarding the timeline for completing the overall plan of care in the case of an IRF interrupted stay.

Answer: The regulations require that an overall plan of care be completed within the first 4 days of the patient's IRF admission. If a patient is out of the IRF in an interrupted stay situation (that is, the patient is discharged from the IRF and returns to the IRF within 3 calendar days), then the days that the patient is "out" of the IRF (that is, the 1, 2, or 3 days between when the patient is formally discharged from the IRF and the time they are formally readmitted to the IRF) will not be counted for determining when the overall plan of care is due.

For example, if a patient is admitted to the IRF on Tuesday, then Tuesday is counted as day "**1**". If the patient goes back to the acute care hospital on Wednesday (day **"2"*),*** and then returns to the IRF on Thursday (day **"3"**) then the IRF will have one extra day to complete the overall plan of care. Thus, the overall plan of care will have to be completed by the end of the day on Saturday (day **"5"**). To take the example a step further, if this same patient was admitted to the IRF on Tuesday, returned to the acute care hospital on Wednesday, and then came back to the IRF on Friday, the IRF would have until the end of the day Sunday (day **"6"**) to complete the overall plan of care (because the patient was out of the IRF on days "**2**" and "**3**").

55. Clarification regarding whether the patient's expected length of stay in the IRF needs to be restated in the patient's overall plan of care if it has already been stated in the documentation of the patient's history and physical exam.

Answer: Yes, the patient's expected length of stay in the IRF must be documented in the overall plan of care.

56. Clarification regarding whether the patient's overall plan of care must be based on the therapy evaluations.

Answer: The individualized overall plan of care must be based on the information from the preadmission screening, the post-admission physician evaluation, and information garnered from any therapy assessments that have been completed prior to the documentation of the overall plan of care. However, in some cases, the rehabilitation physician may have enough information to complete the overall plan of care before any or all of the therapy assessments have been conducted.

57. Clarification regarding whether the 4-day period for completion of the overall plan of care includes the day of admission or starts at midnight of the day of admission.

Answer: The overall plan of care must be completed by the end of the 4th day immediately following the IRF admission, with the day of admission counting as day "1."

58. Clarification regarding the requirement that the IRF-PAI be dated, timed, and signed when it is placed in the IRF medical record.

Answer: To meet the requirement for authenticating entries in the medical record, one signature (attached in some way to the IRF-PAI, either in a cover page or handwritten somewhere on the form) from the person who completed (or transmitted) the IRF-PAI will be sufficient. The IRF-PAI entry should be dated and timed as well.

IX. Technical Issues

59. Clarification regarding the contractor local coverage determinations (LCDs) in relation to the new IRF coverage requirements.

Answer: Change Request 6699, issued January 15, 2010, instructed all Medicare contractors to update existing local coverage determinations (LCDs) of inpatient hospital stays for rehabilitation care to reflect the policies found in the new instructions for coverage in inpatient rehabilitation facilities found in Pub 100-02, Medicare Benefit Policy Manual, chapter 1, section 110 for discharges occurring on or after January 1, 2010.

60. Clarification regarding whether CMS defines a day as a 24 hour period or from midnight to midnight.

Answer: For the purposes of the new IRF coverage requirements, a "day" starts at 12:00 am and ends at 11:59 pm.