

Clarifications for the IRF Coverage Requirements

The attached document combines all of the clarifications for the IRF coverage requirements into one cohesive document. We believe that this format will make it much easier for IRF providers to find the information they are seeking. Simply clicking on the links at the top of the page will populate the section containing the information on that topic.

While organizing the IRF clarifications, we found that there were some duplicative clarifications. In the interest of simplicity, we chose to remove those clarifications that we believed to be redundant. We do want to reiterate that no new clarifications have been added and no language has been changed to the existing clarifications.

After reviewing these clarifications, if you have additional questions about the IRF coverage requirements, please submit your questions to the resource mailbox at IRFCoverage@cms.hhs.gov.

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Pre-Admission Screening

1. Clarification regarding the IRF personnel that may conduct the preadmission screening.

A licensed or certified clinician (or group of clinicians) must conduct the preadmission screening. A licensed or certified clinician is an individual 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. 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.

2. Clarification regarding the timeframes for the rehabilitation physician to document his or her review and concurrence with the preadmission screening.

A rehabilitation physician must review and concur with the findings and results of the preadmission screening after the screening has been completed and prior to the IRF admission. By concurrence, we mean that the rehabilitation physician must either sign and date the original document or, if reviewing from an off-site location, sign and date a copy of the document and fax it to the IRF. This may be done either on the preadmission screening form itself or on a separate document or electronically, as long as it is done prior to the IRF admission.

We will not accept a physician review and concurrence after the patient is admitted to the IRF (i.e., it is not acceptable for the rehabilitation physician to document his or her review and concurrence on the history and physical or the post-admission physician evaluation or on any other documentation that is generated after the patient is admitted to the IRF). It is also not acceptable for the rehabilitation physician to indicate his or her review and concurrence verbally (like a verbal order) by telephone, or for another clinician (such as an Admission Liaison) to

document the rehabilitation physician's verbal review and concurrence with the preadmission screening. Verbal review and concurrence will not be accepted, even if it is followed by written review and concurrence after the IRF admission.

The rehabilitation physician's review and concurrence must be documented by himself or herself prior to the IRF admission. Further, since this documents the decision-making of the rehabilitation physician, this review and concurrence may not be delegated to a physician extender. It is the IRF's responsibility to make sure that the admission decision is documented in the patient's medical record at the IRF, and that the record clearly shows that the decision was made before the admission and reflects the decision-making of a rehabilitation physician.

3. Clarification regarding the use of physician extenders (as defined in Section 1861(s)(2)(K) of the Social Security Act) in the preadmission screening.

The decision regarding whether a patient meets the criteria for admission to an IRF requires a level of physician judgment that cannot be delegated to a physician extender (which, according to Section 1861(s)(2)(K) of the Social Security Act, includes physician assistants, nurse practitioners, and clinical nurse specialists). Thus, a rehabilitation physician (not a physician extender) must document his or her review and concurrence with the findings and results of the preadmission screening prior to the IRF admission. This will not be accepted if done by anyone other than a rehabilitation physician, except in rare situations such as unplanned illness when a rehabilitation physician may not be available. In this case, a physician designated by the IRF to substitute for the rehabilitation physician may document review and concurrence with the preadmission screening. The reason why a rehabilitation physician did not document review and concurrence with the preadmission screening must be documented in the medical record at the IRF. It is important to note that this must not be a regularly repeated occurrence and must not occur because of a planned vacation or leave of absence. For a planned vacation or leave of absence, the IRF must arrange to have another rehabilitation physician available to review and concur with the preadmission screenings.

A dated and timed signature by the rehabilitation physician with one sentence saying that he or she has reviewed and concurs with the findings and results of the preadmission screening is acceptable.

Physician extenders (as defined in Section 1861(s)(2)(K) of the Social Security Act) may conduct the preadmission screening, if they are licensed or certified and if they are 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. Physician extenders may make recommendations to the rehabilitation physician. However, the rehabilitation physician and the IRF are ultimately responsible for admission decisions.

4. Clarification regarding whether CMS will be providing standardized forms for the preadmission screening.

CMS will not be providing standard forms for the preadmission screening. We believe that each IRF should retain the flexibility to determine the best way to meet the preadmission screening requirements within its own organizational structure.

5. Clarification regarding the two methods that may be used to conduct the preadmission screening.

The preadmission screening may be conducted in one of the following two ways:

1. In person—through a face-to-face visit from the IRF clinical staff conducting the preadmission screening, or
2. By telephone—with transmission of the patient’s medical records from the referring hospital and a careful review of those records by the IRF clinical staff responsible for conducting the preadmission screening. The patient’s medical records from the referring hospital must be retained in the patient’s medical record at the IRF.

If the preadmission screening is conducted by telephone, the patient’s medical records from the referring hospital must be retained in the patient’s medical record at the IRF. We expect that appropriate references to the referring hospital’s medical record will be made in the preadmission screening. This data needs to be in the IRF medical record so that it can be available during IRF internal reviews and during CMS medical reviews of IRF claims. We expect that the clinicians assembling the data and performing the preadmission screening will extract the pertinent data from the referring hospital medical record. It is not necessary to include the entire referring hospital medical record if the preadmission screening is conducted by telephone.

However, when evaluating the appropriateness of the admission decision, CMS reviewers can only consider those portions of the referring hospital medical record that are in the IRF medical record. Thus, it is the IRF’s responsibility to ensure that all relevant information was considered when the preadmission screen was conducted.

6. Clarification regarding whether a rehabilitation physician consultation note can serve as the preadmission screening documentation as long as it is written within the time frame and contains the required information.

A rehabilitation physician consultation note may serve as the preadmission screening as long as the rehabilitation physician consultation note contains the required information and is written within the 48 hours immediately preceding the IRF admission (or is written more than 48 hours immediately preceding the IRF admission and is updated within the 48 hours immediately preceding the IRF admission).

7. Clarification regarding the rehabilitation physician’s overall approval of the preadmission screening information versus the need to comment on each individual facet of the preadmission screening information.

The rehabilitation physician is not required to comment on each individual facet of the preadmission screening. In certain instances when a particular facet of the preadmission screening is a key factor in influencing the rehabilitation physician’s decision to admit the patient to the IRF, it would be good practice and would certainly be allowable for the rehabilitation physician to comment on that facet. However, to fulfill the requirement, the rehabilitation physician merely needs to document his or her concurrence with the findings and results of the preadmission screening as a whole, not each individual facet.

8. Clarification on what detailed information must be present in the preadmission screening.

The preadmission screening must include the patient’s prior level of function (prior to the event that caused the need for rehabilitation), the patient’ expected level of improvement, the expected length of time needed to achieve that level of improvement, the risk for clinical complications, the conditions that caused the need for rehabilitation, the combinations of treatments needed in the IRF, the expected frequency and duration of treatment in the IRF, the anticipated discharge destination from the IRF, any anticipated post-discharge treatments, and other information relevant to the patient’s care needs. The preadmission screening documentation must also include documentation of a rehabilitation physician’s review and concurrence with the findings and results of the preadmission screening prior to the IRF admission. This same information is required to be in the preadmission screening documentation for patients admitted to IRFs directly from the community.

9. Clarification regarding whether the preadmission screening, the history and physical, and the post-admission physician evaluation can be combined into one document if a patient is referred to an IRF and transferred all in the same day.

The history and physical and the post-admission physician evaluation certainly can be combined into one document. However, the preadmission screening must be completed prior to the IRF admission and the post-admission physician evaluation must be completed after the IRF admission.

10. Clarification regarding whether the justification for the IRF admission has to be repeated on both the preadmission screening documentation and the post-admission physician evaluation.

Yes. The justification for the IRF admission must be repeated on both the preadmission screening documentation and the post-admission physician evaluation. However, if the patient’s status has not changed, a brief note that references the preadmission screening justification and confirms that the patient status has not changed will be sufficient.

11. Clarification regarding whether the preadmission screening documentation at the IRF can be the same document “carried over” from the acute care hospital, and whether this documentation needs to be in both places.

As long as the preadmission screening documentation at the IRF contains all of the required information, is conducted by a licensed or certified clinician (or clinicians) within the required timeframes, and is reviewed and concurred with by a rehabilitation physician prior to the IRF admission, it meets the requirements regardless of whether the same document appears in the acute care hospital record. This documentation is required to be retained in the patient’s medical record at the IRF. The acute care hospital is required to retain the documentation described in 42 Code of Regulations § 482.24 in the patient’s acute care hospital medical record.

12. Clarification regarding the required format for the preadmission screening information (e.g., electronic, hard copy, etc.) and the rehabilitation physician’s documentation of his or her review and concurrence with the findings and results of the preadmission screening (e.g., signature on the form, faxed signature with date and time, etc).

Since IRFs’ record keeping systems vary, CMS believes that each IRF should retain the flexibility to determine the best way to document both the preadmission screening and to determine that the rehabilitation physician has reviewed and concurs with the findings and results of the preadmission screening within its own organizational structure. Note that, according to 42 Code of Federal Regulations §482.24(c)(1), Medicare payment policy no longer permits the use of rubber stamps as a means of authenticating medical records that support a claim for payment.

13. Clarification regarding “check boxes” on the preadmission screening form.

On the November 12 provider training conference call, CMS indicated that the preadmission screening documentation must not be presented entirely in the form of “check boxes,” but instead must contain some narrative information. Thus, for example, the documentation cannot merely contain “yes/no” check boxes for whether the patient has a risk for clinical complications. It must describe in detail what conditions/comorbidities the patient has and why these indicate a specific risk for clinical complications that require physician monitoring in order for the patient to actively participate in an intensive rehabilitation therapy program. This detailed description, by the very nature of it, would need to be in narrative form. However, the rehabilitation physician is not required to write this narrative if the narrative is written by the licensed or certified clinician/clinicians conducting the preadmission screening.

14. Clarification regarding whether the rehabilitation physician or the licensed or certified clinician/clinicians must write out the detailed reasoning/justification for the IRF admission on the preadmission screening documentation.

The licensed or certified clinician/clinicians conducting the preadmission screening must write out the detailed reasoning/justification for the IRF admission on the preadmission screening documentation. The rehabilitation physician is only required to review and concur with this reasoning/justification. Of course, even though it is not required, the rehabilitation physician may

conduct the preadmission screening, in which case he or she would write the reasoning/justification narrative. In all cases, however, the rehabilitation physician is responsible for the accuracy and completeness of the preadmission screening documentation.

15. Clarification regarding whether the preadmission screening documentation must be a permanent part of the patient's medical record at the IRF.

Yes. The preadmission screening documentation must now be a permanent part of the patient's medical record at the IRF.

16. Clarification on whether the diagnoses on the preadmission screening and the post-admission physician evaluation must agree.

The diagnoses on the preadmission screening and the post-admission physician evaluation must correspond with other information in the patient's medical record, and generally will be the same. However, there could be rare instances when the two sets of diagnoses could be different, reflecting significant changes in the patient's condition between the preadmission screening and the post-admission physician evaluation. The reasons for these changes should be documented in the post-admission physician evaluation.

17. Clarification regarding whether family physicians or internal medical physicians or other types of physicians (besides rehabilitation physicians) can review and concur with the preadmission screening in place of a rehabilitation physician.

A rehabilitation physician is uniquely qualified to determine whether a patient is appropriate for IRF care or not. Thus, according to the regulations, it must be a rehabilitation physician with specialized training and experience in rehabilitation who reviews and concurs with the preadmission screening prior to the IRF admission.

However, we recognize that, in rare situations such as unplanned illness, a rehabilitation physician may not be available. In this case, a physician designated by the IRF to substitute for the rehabilitation physician may document review and concurrence with the preadmission screening. The reason why a rehabilitation physician did not document review and concurrence with the preadmission screening must be documented in the medical record at the IRF. It is important to note that this must not be a regularly repeated occurrence and must not occur because of a planned vacation or leave of absence. For a planned vacation or leave of absence, the IRF must arrange to have another rehabilitation physician available to review and concur with the preadmission screenings.

18. 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.

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.

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

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.

20. Clarification regarding whether an abbreviated “short form” version of the preadmission screening could be done on weekends.

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.

21. 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).

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.

22. 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.

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.

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

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.

24. 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).

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.

25. 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.

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).

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

No.

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

No.

28. Timing of the physician’s review and concurrence with the preadmission screening

The rehabilitation physician must document concurrence with the findings and results of the preadmission screening after the screening is completed and before the patient is admitted to the IRF.

29. Use of clinicians versus certified nurse aides in the preadmission screening process

As we indicated in the FY 2010 IRF PPS final rule, the clinician(s) conducting the preadmission screening must “be 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” and must be licensed or certified . While a nurse aide may be certified, a nurse aide is not 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.

30. Use of clinical/non-clinical personnel in the preadmission screening process

Although clinical personnel are required to evaluate the preadmission screening information, each IRF may determine its own processes for collecting and compiling the preadmission screening information. The focus of the review of the preadmission screening information will be on its completeness, accuracy, and the extent to which it supports the appropriateness of the IRF admission decision, not on how the process is organized.

31. Clarification regarding whether email or BlackBerry® transmissions are an allowable means of documenting the rehabilitation physician’s review and concurrence with the preadmission screening prior to an IRF admission.

A rehabilitation physician must review and concur with the findings and results of the preadmission screening after the screening has been completed and prior to the IRF admission. By concurrence, we mean that the rehabilitation physician must either sign and date the original document or, if reviewing from an off-site location, sign and date a copy of the document and fax it to the IRF. This may be done either on the preadmission screening form itself or on a separate document or electronically, as long as it is done prior to the IRF admission. Efforts are currently underway at CMS to develop overall policies for the use of electronic signatures (e-signatures) for Medicare transactions. Until such efforts are completed and new policies have been established, we cannot allow the preadmission screening concurrence to be documented through any other means except as a signature on the original document or on a copy of the document that is faxed to the IRF.

32. We recently issued the following clarification on the use of Blackberry ® or email to document the rehabilitation physician’s review and concurrence with the required preadmission screening for IRF services:

A rehabilitation physician must review and concur with the findings and results of the preadmission screening after the screening has been completed and prior to the IRF admission. By concurrence, we mean that the rehabilitation physician must either sign and date the original document or, if reviewing from an off-site location, sign and date a copy of the document and fax it to the IRF. This may be done either on the preadmission screening form itself or on a separate document or electronically, as long as it is done prior to the IRF admission. Efforts are currently underway at CMS to develop overall policies for the use of electronic signatures (e-signatures) for Medicare transactions. Until such efforts are completed and new policies have been established, we cannot allow the preadmission screening concurrence to be documented through any other means except as a signature on the original document or on a copy of the document that is faxed to the IRF.

Subsequent to the posting of this clarification, we have received additional questions about the use of a closed electronic medical record system to generate the preadmission screening documentation and to document the rehabilitation physician’s review and concurrence with this information. As we understand it, these systems enable the preadmission screening documentation to be generated entirely electronically. Then, when the preadmission screening documentation is completed, the rehabilitation physician logs into the system with his or her own password, reviews all of the information, and designates with an electronic signature (that also has a date and time stamp) that he or she has reviewed and concurs with the preadmission screening documentation.

As described above, such closed electronic medical record systems are an acceptable means of documenting the rehabilitation physician’s review and concurrence with the preadmission screening. In contrast to the transmittal of documents through Blackberry ® or email, closed electronic medical record systems provide two levels of assurance that we believe are critical for ensuring the integrity of the process:

1. They ensure the security of personally identifiable information (PII), as required under the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II), and
2. They tie the preadmission screening information together with the rehabilitation physician’s documentation of his or her review and concurrence with the information, rather than allowing the two pieces of information to be separate and disconnected.

When CMS completes the development of Medicare’s formal electronic signature policies, we may need to revise or further clarify this guidance to ensure that it is in accordance with those policies.

Post-Admission Physician Evaluation and History and Physical

1. Clarification regarding whether a history and physical that includes all of the required elements for the post-admission physician evaluation would satisfy the requirement for a post-admission physician evaluation and whether this document must be re-named “post-admission physician evaluation.”

A history and physical that includes all of the required elements for the post-admission physician evaluation and that is done by a rehabilitation physician within the first 24 hours of the IRF admission meets the requirement for the post-admission physician evaluation. It must be apparent to a medical review entity that the expanded history and physical is being used for the post-admission physician evaluation, so it would be good practice (though not required) to indicate this in the title of the document.

If a resident or a physician extender (defined in section 1861(s)(2)(K) of the Social Security Act to include physician assistants, nurse practitioners, and clinical nurse specialists) has completed the history and physical, a rehabilitation physician is not required to repeat the history and physical exam, but he or she must visit the patient and complete the other required parts of the post-admission physician evaluation within the 24 hours immediately following the IRF admission.

2. Clarification regarding the use of physician extenders, including residents, in completing the history and physical and the post-admission physician evaluation.

The usual Medicare regulations regarding the use of physician extenders and residents in providing services to Medicare beneficiaries apply to completion of the history and physical. However, a rehabilitation physician must visit the patient and complete the other required parts of the post-admission physician evaluation within the 24 hours immediately following the IRF admission.

3. Clarification regarding the required content for the post-admission physician evaluation.

The post-admission physician evaluation must identify any relevant changes that have occurred since the preadmission screening. It also must include a documented history and physical exam, and a review of the patient’s prior and current medical and functional conditions and comorbidities. As such, it also serves as the basis for the individualized overall plan of care. Note that, according to the regulations in 42 Code of Federal Regulations §482.24(c)(1), the post-admission physician evaluation (like all entries in the medical record) must be dated, timed, and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided.

4. Clarification regarding the availability of standard forms for the post-admission physician evaluation.

CMS will not be providing standard forms for the post-admission physician evaluation. We believe that each IRF should retain the flexibility to determine the best way to meet this requirement within its own organizational structure.

5. Clarification regarding whether the history and physical exam can be done by one physician and the post-admission physician evaluation can done by another physician or whether the same physician must do both.

The history and physical and the post-admission physician evaluation do not have to be performed by the same individual.

6. Clarification regarding whether the rehabilitation physician or the interdisciplinary team or both are responsible for completing the post-admission physician evaluation.

The post-admission physician evaluation is the sole responsibility of the rehabilitation physician. Although it would certainly be good practice for the rehabilitation physician to consider any available input from the interdisciplinary team members, the interdisciplinary team is not required to be involved in the post-admission physician evaluation.

7. Clarification regarding to what extent an evaluation (or a history and physical) has to be repeated after admission to an IRF if the patient has been evaluated by the same rehabilitation physician just prior to admission to the IRF.

The rehabilitation physician is responsible for ensuring that the information in the post-admission physician evaluation is accurate, up-to-date, and fully supports the IRF admission decision. Thus, he or she must update any information necessary to ensure that the information is up-to-date. However, if the patient's status has not changed, a brief note that references the previous evaluation and confirms that the patient's status has not changed will be sufficient.

8. Clarification of whether the post-admission physician evaluation and the overall plan of care can be completed at the same time and be in the same document.

As long as both pieces of documentation (the post-admission physician evaluation and the overall plan of care) contain all of the required elements and are completed within the required timeframes, they can be completed at the same time and be included in the same document. However, it must be clearly documented that both requirements are included in the document.

9. Clarification regarding whether a post-admission physician evaluation is still required to be completed within 24 hours of the IRF admission to document any changes or confirm the findings of the history and physical if the history and physical was just completed hours before the patient's transfer to the IRF.

A post-admission physician evaluation is required to be completed for all IRF admissions, regardless of how recently prior to the admission the patient was evaluated. However, the rehabilitation physician may use information from the referring hospital evaluation when completing the post-admission physician evaluation.

10. 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.

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.

11. 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.

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.

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

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.

13. 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.

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.

14. Use of a physician’s history and physical (H&P) in the post-admission physician evaluation.

If an H&P is performed by a rehabilitation physician within the first 24 hours of the IRF admission and if it contains all of the elements required in the post-admission physician evaluation, it would satisfy the requirement for the post-admission physician evaluation.

15. 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).

Overall Plan of Care and Interdisciplinary Team Meeting

1. Clarification regarding whether the first interdisciplinary team meeting has to occur within the first 4 days of admission to complete the overall plan of care.

Though it might be good practice, the first team meeting does not have to occur in the first 4 days to establish the overall plan of care. The overall plan of care is the rehabilitation physician’s responsibility.

2. Clarification of the difference between the overall plan of care and the interdisciplinary team meeting.

The purpose of the overall plan of care is for the rehabilitation physician to bring together all of the information that has been collected on the patient’s medical and functional treatment needs and goals in the beginning of the IRF stay, and to synthesize this information into an overall plan of care that will guide the patient’s treatment during the IRF stay. The required elements of the overall plan of care are described in section 110.1.3 of the Medicare Benefit Policy Manual (Pub. 100-02). The overall plan of care must build on information from the preadmission screening and the post-admission physician evaluation, and must include information gained from the individual therapy assessments. This forms the initial treatment plan for the patient.

The interdisciplinary team must then meet weekly in order to do the following:

- Assess the patient’s progress towards the rehabilitation goals,
- Consider possible resolutions to any problems that could impede progress towards the goals,
- Reassess the validity of the rehabilitation goals previously established, and

- Monitor and revise the treatment plan, as needed.

3. Clarification regarding whether the rehabilitation physician has to write out the entire plan of care him/herself.

The rehabilitation physician does not have to write out (or dictate) the entire plan of care him/herself, although it is certainly acceptable if he or she chooses to do so. There are many possible ways of developing the overall plan of care, and we believe that the IRF and the rehabilitation physician should retain the flexibility to determine the best way to meet this documentation requirement within the organizational structure of the IRF.

Depending on the organizational structure of the IRF, the rehabilitation physician may, for example, write out (or dictate) the overall plan of care or bring together (synthesize) the individual plans of care from the different treating disciplines and modify or add to these individual discipline plans of care, as appropriate.

The purpose of the overall plan of care is to provide a general direction for the patient's care in the IRF and to document broad goals for the patient's treatment in the IRF that will then be used by each discipline to further refine their individual plans of care, as appropriate.

4. Clarification regarding the availability of standard forms for the overall plan of care.

CMS will not be making standard forms available for the individualized overall plan of care.

These should be individualized to the unique circumstances and care needs of the patient.

Further, we believe that each IRF should retain the flexibility to determine the best way to meet these requirements within its own organizational structure.

5. Clarification regarding what CMS means by an “individualized” overall plan of care.

We emphasize the word “individualized” in the context of the overall plan of care because each overall plan of care must be tailored to the unique care needs of the patient. No two overall plans of care are exactly alike.

6. Clarification regarding whether the overall plan of care can be combined with the history and physical and/or the post-admission physician evaluation documentation and whether the overall plan of care has to repeat information from these documents.

The individualized overall plan of care must build off of the history and physical and the post-admission physician evaluation. Thus, it can be an extension of these documents, and does not necessarily have to repeat all of the information contained in these documents. Further, it can be completed at the same time as the post-admission physician evaluation (i.e., within the first 24 hours of the IRF admission).

7. Clarification regarding whether the overall plan of care can be done anytime within the first 4 days of admission to the IRF (i.e., on day 2 or 3, if all of the information is known at that time).

The overall plan of care must be completed by the end of the 4th day immediately following the IRF admission. It is acceptable to complete the overall plan of care on days 1, 2, 3, or 4 of the IRF admission.

8. Clarification regarding whether a physician extender can assist the rehabilitation physician in developing the overall plan of care for his or her approval and signature.

Yes. Physician extenders working in collaboration with the rehabilitation physician can assist the rehabilitation physician in developing the overall plan of care for his or her approval and signature. We believe that the IRF and the rehabilitation physician should retain the flexibility to determine the best way to satisfy this requirement within the organizational structure of the IRF.

9. Clarification regarding the weekly interdisciplinary team meeting requirement.

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.

10. 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.

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

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

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.

12. 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.

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.

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

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>).

14. 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.

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.

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

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.

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

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.

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

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.

18. 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.

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.

19. 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.

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

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

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.”*

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

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").

22. 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.

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

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

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.

24. 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.

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.”

25. Clarification regarding whether certified occupational therapy assistants and physical therapy assistants may be the representatives of their respective therapy disciplines at the interdisciplinary team meetings.

The regulations state that the interdisciplinary team meetings must focus on the following:

- Assessing the individual's progress towards the rehabilitation goals;
- Considering possible resolutions to any problems that could impede progress towards the goals;
- Reassessing the validity of the rehabilitation goals previously established; and
- Monitoring and revising the treatment plan, as needed.

Generally, state licensure laws preclude therapy assistants from evaluating patients and establishing or revising/modifying plans of care, which are some of the core functions of the interdisciplinary team meeting. Since therapy assistants cannot perform the core functions of the interdisciplinary team meetings, then they cannot represent their respective disciplines at the meetings.

26. Clarification regarding whether all participants in the weekly interdisciplinary team meetings are required to sign the documentation of the meetings.

Signatures from the participants in the weekly interdisciplinary team meetings are not required. Chapter 1, Section 110.2.5 of the Medicare Benefit Policy Manual (Pub. 100-02) requires only that the documentation, “include the names and professional designations of the participants in the team conference.”

27. 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

Admission Orders

1. Clarification regarding why the admission orders language was revised.

At the time of admission, a physician must generate admission orders for the patient’s care that must be retained in the patient’s medical record at the IRF. This admission orders requirement is not substantively different from the previous admission orders requirement. CMS just revised the wording somewhat to make it more clear when the orders must be generated and that the orders must be retained in the patient’s medical record at the IRF.

2. Clarification regarding whether the admission orders can be given verbally, including whether they can be given to a registered nurse by the physician over the phone.

The physician may dictate the admission orders, but the orders themselves must be written and retained in the patient’s medical record at the IRF.

3. Clarification regarding whether the admission orders can be generated by an internist or a family practice physician or another type of physician, or whether they must be generated by a rehabilitation physician.

Any licensed physician may generate the admission orders. It does not have to be a rehabilitation physician.

4. Clarification regarding whether a physician extender (such as a nurse practitioner or a physician assistant) can generate the admission orders.

A physician extender, working in collaboration with the physician, may generate the admission orders.

5. 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.

6. Clarification as to whether or not facilities can have longer than 3 days to place a patient who is not appropriate for IRF care (e.g., some patients need special psychiatric paperwork to be completed before a SNF will accept them).

The IRF is not prohibited from keeping the patient for longer than three days. However, the IRF is only eligible to receive Medicare reimbursement based upon the short stay payment for IRF stays of three days or fewer.

7. Clarification regarding payment for an admission if it takes longer than 3 days for the IRF to discharge a patient who no longer meets the coverage criteria and why CMS is restricting payment to the CMG for patient stays of 3 days or less.

In the unusual instance that the rehabilitation physician's reasonable expectation prior to admission is not realized once the patient is admitted to the IRF, the IRF must immediately begin the discharge process. Although CMS would typically deny payment for services that are not reasonable and necessary, we recognize that mistakes may occur despite the best efforts of the IRF in conducting a thorough preadmission screening. We also recognize that the patient's medical or functional condition could change between the preadmission screening and the time of the IRF admission. To account for these possibilities, we will allow the IRF to receive the IRF short stay payment for stays of three days or fewer.

IRF-PAI

1. Clarification regarding whether the IRF-PAI form included in the patient's medical record at the IRF must have a data entry date and time.

According to 42 Code of Federal Regulations §482.24(c)(1), all entries in the medical record must be dated, timed, and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided.

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

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.

3. Clarification regarding whether the discharge dates on the IRF patient assessment instrument (IRF-PAI) and the discharge dates on the IRF claim must be the same.

As we stated on the May 31, 2012 IRF Coverage Requirements National Provider Call, we believe that the discharge dates on the IRF-PAI should always match the discharge dates on the IRF claims. Thus, we removed language from the IRF-PAI Training Manual (effective October 1, 2012) that may have led providers to believe that they could put different discharge dates on the IRF-PAI than on the claim. Although previous guidance in the IRF-PAI Training Manual

suggested that patients could be downgraded from a Medicare Part A IRF stay by “discharging” the patient on the IRF-PAI when the patient no longer required an IRF level of care, this guidance is no longer consistent with Medicare regulations. As stated in Chapter 1, Section 110.3 of the Medicare Benefit Policy Manual (Pub. 100-02), “Since discharge planning is an integral part of any rehabilitation program and must begin upon the patient’s admission to the IRF, an extended period of time for discharge from the IRF would not be reasonable and necessary after established goals have been reached or the determination has been made that further progress is unlikely.” We believe that it is in the patient’s best interest for the IRF to begin the discharge planning process early and continue it throughout the IRF stay. Thus, although we allow a brief period for the IRF to find alternative placement for a patient who no longer meets the IRF coverage criteria, an extended stay in the IRF for such patients is not warranted.

In the very rare case in which it may become apparent that the patient’s discharge from the IRF is going to be delayed for an extended period of time, the IRF should provide the patient with an Advance Beneficiary Notice (ABN) informing the patient that he or she may be liable for any remaining charges. The IRF should also use occurrence code 76 on the IRF claim for the remaining days to indicate that those days are not Medicare-covered under the IRF prospective payment system. Otherwise, the IRF claim will continue to be considered a Medicare Part A stay and will continue to be subject to review under the IRF coverage requirements.

4. Clarification regarding start and end time when coding concurrent or group therapy on the IRF PAI.

When conducting concurrent and group therapy sessions, start and end times do not need to be the same for all patients participating. The exact time spent for each individual participating in a concurrent or group therapy session should be reported as such. Any additional time either prior to or following participation in a group or therapy session that an individual receives one-on-one therapy should be recorded as individual therapy. We believe that providers will be able to accurately and effectively document the amount of time that the patient is receiving therapy, as well as the correct mode.

Example 1: Mr. A begins PT to address lower extremity strengthening at 9:00 am. Mrs. G enters at 9:30 am and begins working with the same therapist on upper extremity range of motion. Both patients engage with the PT until 10:00 am. At that time, Mr. A leaves and Mrs. G continues with her exercises until 10:30 am.

Mr. A’s therapy time should be coded as:

Total minutes of Individual therapy: 30 minutes (9:00am to 9:30am)

Total minutes of Concurrent therapy: 30 minutes (9:30am to 10:00am)

Mrs. G’s therapy time should be coded as:

Total minutes of Concurrent therapy: 30 minutes (9:30am to 10:00am)

Total minutes of Individual therapy: 30 minutes (10:00am to 10:30am)

Example 2: An SLP is working with Patients A, B, C, and D in a communication group. At 2:00pm, the group begins with all four patients present. At 2:12 pm, Patient A leaves to go to the bathroom and returns at 2:28 pm. At 2:37 pm, Patient B leaves for an appointment and does not return. The communication group ends at 3:00 pm. This scenario should be coded as follows:

Patient A:

Total minutes of Group therapy: 44 minutes (2:00pm to 2:12pm, 2:28pm to 3:00pm)

Patient B:

Total minutes of Group therapy: 37minutes (2:00pm to 2:37pm)

Patient C:

Total minutes of Group therapy: 60 minutes (2:00pm to 3:00pm)

Patient D:

Total minutes of Group therapy: 60 minutes (2:00pm to 3:00pm)

NOTE: If at any time, there is only one patient remaining from the original group, then the time spent with this patient would be coded as individual therapy.

NOTE: One therapist can only provide one mode of therapy at a time. Therapy may only be comprised of one group session or one concurrent session or one individual session.

5. Clarification regarding how to code item #24 (indicating whether arthritis conditions meet the 60 percent rule regulatory requirements) on the patient's IRF-PAI for patients who do not have any arthritis conditions recorded in items #21, #22, or #24.

If the patient does not have any arthritis conditions recorded in items #21, #22, or #24 of the IRF-PAI, then the IRF should code "0 – No" in item #24A.

Multiple Therapy Disciplines

1. Clarification regarding the use of therapy technician/aide services and certified occupational therapy assistants and physical therapy assistants in IRFs and whether these services would count towards demonstrating the intensity of therapy requirement in an IRF.

For detailed guidance on the required qualifications of a therapist, required skills of a therapist, and medically necessary and appropriately documented therapy services, please see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, sections 220 and 230. The policies in those sections describe a standard of care that should be consistent throughout the therapy disciplines, regardless of the setting of care. Therapy technician/aides are limited to performing administrative and support functions and cannot be directly involved in the provision of therapy services to the beneficiary. Certified occupational therapy assistants and physical therapy assistants may provide therapy services to beneficiaries under the appropriate supervision of licensed therapists.

2. Clarification regarding the requirement that patients need multiple therapy disciplines, at least one of which must be physical or occupational therapy.

A primary distinction between the IRF environment and other rehabilitation settings is the interdisciplinary approach to providing rehabilitation therapy services in an IRF. Patients requiring only one discipline of therapy would not need this interdisciplinary approach to care and therefore do not need to be treated in an IRF.

3. Clarification of how an IRF must document that a patient needs occupational and physical therapy in the IRF when that patient has only received physical therapy in the referring hospital.

The pre-admission screening must demonstrate that there is a reasonable expectation that, on admission to the IRF, the patient needs multiple therapy disciplines, at least one of which must be physical or occupational therapy.

4. Clarification regarding the use of group therapies in IRFs.

CMS has not yet established standards for the provision of group therapies in IRFs. However, as we stated in the FY 2010 IRF PPS final rule, the standard of care for IRF patients is individualized therapy. We do not believe that an IRF providing the preponderance of therapy in the form of group therapy would be demonstrating the intensity of therapy required in an IRF.

5. Clarification regarding the use of concurrent therapies in IRFs.

CMS has not yet established standards for the provision of concurrent therapies in IRFs. However, we do not believe that an IRF providing the preponderance of therapy in the form of concurrent therapy would be demonstrating the intensity of therapy required in an IRF.

Intensive Rehabilitation Therapy Program

1. Clarification of the different ways in which an IRF may demonstrate the intensity of therapy requirement.

Although the intensity of rehabilitation services can be reflected in various ways, the generally-accepted standard by which the intensity of these services is typically demonstrated in IRFs is by the provision of intensive therapies at least 3 hours per day at least 5 days per week. However this is not the only way such intensity could be demonstrated. The intensity of therapy provided in an IRF could also be demonstrated by the provision of 15 hours of therapy per week (that is, in a 7 consecutive day period starting with the day of admission), as long as the reasons for the patient's periodic need for this program of intensive rehabilitation is well-documented in the patient's medical record at the IRF and the overall amount of therapy is "intensive" and can reasonably be expected to benefit the patient. For example, if a hypothetical IRF patient was admitted to an IRF for a hip fracture, but was also undergoing chemotherapy for an unrelated issue, the patient might not be able to tolerate therapy on a predictable basis due to the chemotherapy. Thus, this hypothetical patient might be more effectively served by the provision of 4 hours of therapy 3 days per week and 1 ½ hours of therapy on 2 (or more) other days per week in order to accommodate his or her chemotherapy schedule.

2. Clarification on whether or not therapy evaluations and re-evaluations count as the initiation of therapy services and whether they count toward demonstrating the intensity of therapy requirement in IRFs.

Therapy evaluations do count as the initiation of therapy services. They may also be used to demonstrate the intensity of therapy services provided in IRFs.

3. Clarification on whether or not a therapist can complete the therapy evaluation of the patient while that patient is still in the referring hospital (for example, the acute care hospital) waiting to be transferred to the IRF and whether or not therapies done in the referring hospital count towards demonstrating the intensity of therapy requirement if performed on the same day that a patient is discharged from the referring hospital and admitted to the IRF.

Evaluations and/or therapy done in the referring hospital do not count in the IRF for purposes of meeting the intensity of therapy requirement.

4. Clarification regarding the day of admission as day “1” of the week for demonstrating the required intensity of therapy requirement and whether the initiation of therapy 36 hours from midnight of the day of admission starts the therapy “clock”.

The day of admission is day “1” for the required intensity of therapy requirement. No matter what time of day the patient is admitted to the IRF, the day of admission counts as day “1” and represents the start of the therapy “clock”.

5. Clarification as to whether or not a patient who is admitted Wednesday, with therapy evaluations done on Thursday, must receive therapy on a weekend day (Saturday or Sunday) in order to document the intensity of therapy requirement.

In many instances, patients admitted later in the week must receive therapy services on at least one of the days of the weekend to document the required intensity of therapy program provided in the IRF.

6. Clarification as to whether or not neuropsychology is one of the therapies that can be used to document the intensity of therapy requirement.

While we believe that IRFs should provide, as needed, psychological and neuropsychological services to IRF patients, these services are separately billable under Medicare Part B, as described in § 411.15(m)(3)(i) and § 411.15(m)(3)(v), and are not included in the IRF PPS payment. Thus, while we would expect the IRF to provide appropriate medical oversight of any medical or psychiatric problem that is present on admission or develops during the stay (in accordance with the overall hospital Conditions of Participation at § 482.12(c)(1)(i), (c)(1)(vi), and (c)(4)), psychological and neuropsychological services furnished pursuant to this responsibility would not be considered part of the required intensity of therapy services that Medicare pays for under the Part A benefit that includes payment for IRF PPS services.

7. 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.

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.

8. 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.

9. 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.

10. 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.

11. 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.

12. 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.

13. 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.

14. 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.

Adjunct Therapies

1. Clarification on whether or not recreational therapy, music therapy, respiratory therapy, neuropsychology, or cognitive therapy can be used to satisfy the requirement for patients to receive intensive rehabilitation therapy in IRFs. If not, are recreational therapy

services a covered service in IRFs when the medical necessity is well-documented by the rehabilitation physician and they are ordered by a rehabilitation physician as part of the patient’s overall plan of care?

While we believe that IRFs should provide, as needed, psychological and neuropsychological services to IRF patients, these services are separately billable under Medicare Part B, as described in § 411.15(m)(3)(i) and § 411.15(m)(3)(v), and are not included in the IRF PPS payment. Thus, while we would expect the IRF to provide appropriate medical oversight of any medical or psychiatric problem that is present on admission or develops during the stay (in accordance with the overall hospital Conditions of Participation at § 482.12(c)(1)(i), (c)(1)(vi), and (c)(4)), psychological and neuropsychological services furnished pursuant to this responsibility would not be considered part of the required intensity of therapy services that Medicare pays for under the Part A benefit that includes payment for IRF PPS services. Further, we do not believe that it is appropriate to mandate that all IRFs provide recreational therapy, music therapy, or respiratory therapy services to all IRF patients, as such services may be beneficial to some, but not all, patients as an *adjunct* to other, primary types of therapy services provided in an IRF (physical therapy, occupational therapy, speech-language pathology, and prosthetics/orthotics). We do not believe that they should replace the provision of these core skilled therapy services. Thus, we believe that it should be left to each individual IRF to determine whether offering recreational therapy, music therapy, or respiratory therapy is the best way to achieve the desired patient care outcomes.

While we are not adding these therapies to the list of required therapy services in IRFs, we do recognize that they are Medicare covered services in IRFs if the medical necessity is well documented by the rehabilitation physician in the medical record and is ordered by the rehabilitation physician as part of the overall plan of care for the patient. However, consistent with our longstanding policies and standard practices, these therapy activities are not used to demonstrate that a patient has received intensive therapy services.

Medical Necessity

1. Clarification on whether or not patients must have suffered “an acute impairment” for admission to an IRF or whether patients who experience a functional decline due to a chronic condition may be admitted to an IRF.

We did not intend to limit the IRF benefit to only those patients who have suffered an acute impairment prior to being admitted to an IRF. While this is the typical type of patient who receives treatment in an IRF, patients who have suffered a functional decline due to a chronic condition may be appropriately treated in IRFs if they meet all of the IRF coverage criteria specified in the regulation and in section 110 of the Medicare Benefit Policy Manual.

2. Clarification on whether CMS would consider the provision of 15 hours per week of intensive therapy services to be an appropriate treatment plan in an IRF for patients receiving dialysis treatments.

Depending on the patient’s ability to tolerate therapy on the days that dialysis is performed, the provision of 15 hours per week of therapy could be considered an appropriate treatment plan in an IRF for many dialysis patients. The reasons for this therapy schedule, or any other therapy schedule, must be well-documented in the patient’s medical record at the IRF, and the overall amount of therapy must be “intensive” and must be reasonably be expected to benefit the patient.

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’s expected (or actual) discharge destination from the IRF will affect whether an IRF claim will be considered “reasonable and necessary”.

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.

Rehabilitation Physician and Staff Qualifications

1. Clarification regarding the qualifications of the rehabilitation physician.

The rehabilitation physician is a licensed physician (not necessarily a salaried employee of the IRF) who has specialized training and experience in rehabilitation. It is the responsibility of each IRF to ensure that the rehabilitation physicians that are making the admission decisions and caring for patients are appropriately trained and qualified. While the IRF must continue to meet the hospital conditions of participation specified in 42 Code of Federal Regulations §482.22 regarding documentation of staff qualifications, we do not require specific documentation in the patient’s medical record to demonstrate the rehabilitation physician’s qualifications.

2. Clarification of the rehabilitation nursing requirements.

An IRF must comply with the requirements for nursing set forth in the Hospital Conditions of Participation at 42 CFR §482.23 of the regulations. In addition, the interdisciplinary team must include a registered nurse with specialized training or experience in rehabilitation.

3. 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.

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.

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

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.

5. 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.

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.

6. Clarification regarding whether all IRF referrals have to be reviewed by a rehabilitation physician, or only those who are found to be appropriate for IRF admissions.

The IRF is required to maintain documentation of a rehabilitation physician’s review and concurrence with the IRF admission for all Medicare beneficiaries admitted to the IRF. The IRF

is not required to keep such documentation for Medicare beneficiaries who are not admitted to the IRF.

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

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.

Three Face-to-Face Physician Visits

1. 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.

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.

2. Clarification as to whether the post-admission physician evaluation may serve as one of the three required rehabilitation physician visits in the first week.

No. The post-admission physician evaluation and the required minimum of three face-to-face rehabilitation physician visits per week serve different purposes, and the requirements may not be combined.

The post-admission physician evaluation documents the patient's status on admission and provides the rehabilitation physician with the necessary information to begin development of the patient's overall plan of care. The ongoing rehabilitation physician visits ensure that the patient's medical status and functional status are being continuously monitored as the patient's overall plan of care is being carried out, so that the patient can ultimately achieve his or her highest functional recovery. One of the requirements of the minimum three rehabilitation physician visits per week is to assess the patient's functional goals and progress in light of the patient's medical conditions. We do not believe that a rehabilitation physician can do a meaningful assessment of the patient's progress in light of the intensive rehabilitation therapy program before the patient has received at least one full day's worth of intensive rehabilitation therapy.

Therapy

1. 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.

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.

2. 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.

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.

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

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.

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

If the patient receives 15 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.

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

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.

6. 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.

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.

7. 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.

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.

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

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.

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

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.

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

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.

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

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).

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

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.

13. Clarification on whether it is acceptable to round the number of minutes of therapy.

Therapy minutes cannot be rounded for the purposes of documenting the required intensity of therapy provided in an IRF.

14. Clarification regarding whether the documentation of the intensive rehabilitation therapy program in IRFs must be reported in minutes or may be reported in 15-minute increment units.

It is up to the IRF exactly how they wish to document the number of minutes of therapy provided to the patient. However, therapy minutes cannot be rounded for the purposes of documenting the required intensity of therapy provided in an IRF (for example, 8 minutes of therapy cannot be rounded up to a 15-minute increment of therapy, as is sometimes done in other settings). A 15-minute increment unit reported for an IRF patient must mean that the patient actually received the full 15 minutes of intensive therapy.

15. Clarification regarding whether IRFs are required to provide therapy on weekends and/or holidays.

Regardless of weekends and holidays, IRFs are expected to comply with all of the coverage requirements. It is standard practice for IRFs to plan for weekends and holidays to execute patients' plans of care.

16. 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.

17. 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.

18. 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.

19. Clarification regarding the meaning of the requirement to document the expected amount of therapy time "by discipline" and whether an IRF claim could be subject to denial if the expected amount of therapy time by discipline varies from one day to the next.

The expected amount of therapy time by discipline required during the IRF stay must be documented on the individualized overall plan of care. This means that the rehabilitation physician must document the amount of expected physical therapy, occupational therapy, speech-language pathology, and orthotics/prosthetics the patient is expected to need on a daily

basis in the IRF. Day-by-day variation in the expected amount of therapy by discipline is acceptable as long as it reflects the unique care needs of the patient.

It is not acceptable to simply use a generalized phrase such as, “At least 3 hours per day, at least 5 days per week” on the individualized overall plan of care. This is not individualized to the unique care needs of the patient and does not indicate the expected amount of therapy by discipline. To meet the requirement, the overall plan of care must indicate the type and expected amount of physical therapy, occupational therapy, speech-language pathology, and orthotics/prosthetics needed by the patient on a daily basis. This must be unique to the individual care needs of the patient.

20. Clarification as how a patient who is ill would meet the intensity of therapy requirement and whether or not the “missed hours” would need to be made up on the weekend.

While patients requiring an IRF stay are expected to need and receive an intensive rehabilitation therapy program, as described above, this may not be true for a limited number of days during a patient’s IRF stay because patients’ needs vary over time. For example, if an unexpected clinical event occurs during the course of a patient’s IRF stay that limits the patient’s ability to participate in the intensive therapy program for a brief period not to exceed 3 consecutive days (e.g., 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, surgical procedure, etc.), the specific reasons for the break in the provision of therapy services must be documented in the patient’s IRF medical record. If these reasons are appropriately documented in the patient’s IRF medical record, such a break in service (of limited duration) will not affect the determination of the medical necessity of the IRF admission. Thus, Medicare contractors may approve brief exceptions to the intensity of therapy requirement in these particular cases if they determine that the initial expectation of the patient’s active participation in intensive therapy during the IRF stay was based on a diligent preadmission screening, post-admission physician evaluation, and overall plan of care that were based on reasonable conclusions.

21. 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.

22. 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 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.

23. Clarification regarding the percentage of one-on-one individualized therapy that would constitute the “bulk” of therapy.

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.

Payment and Technical

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

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.

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

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).

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

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

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

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.

5. Clarification regarding the difference between the estimated length of stay and the duration of therapy treatments.

The duration of therapy treatments must be indicated by discipline, whereas the estimated length of stay is an overall number of days. For example, while the estimated length of stay for a hypothetical patient could be 21 days, the patient could require speech-language pathology treatments for days 1 through 10, and require orthotics/prosthetics on days 10 through 21 of the stay.

6. 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.

7. 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.

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.

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

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.

9. 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.

10. Clarification regarding what CMS meant by the term "trial" patients and whether patients may still be admitted to IRFs on a "trial" basis.

Previously, the Medicare Benefit Policy Manual had a provision for patients to be admitted to IRFs for 3 to 10 day periods to assess whether the patients could benefit from an IRF level of care. These were sometimes called “trial” admissions. As we stated in the final rule, CMS will no longer cover a stay in the IRF where the primary purpose of the stay is to assess the patient’s need for intensive rehabilitation. Instead, the IRF is expected to admit only those patients who, on admission, are reasonably expected to meet the stated coverage criteria.

The current average length of stay for IRF patients is only about 13 days, and the average length of stay for many orthopedic patients treated in IRFs is only about 8 days. Given this, we believe that it is no longer appropriate to allow up to 10 days in an IRF merely to assess the patient. At that point, the average IRF patient would already be preparing to be discharged. In addition, we believe that, in today’s clinical environment, licensed physicians with training and experience in rehabilitation are able to assess a patient prior to admission to an IRF and determine whether there is a reasonable expectation that the patient can participate in and benefit from treatment in an IRF.