



New Coverage Policies for Inpatient Rehabilitation Services



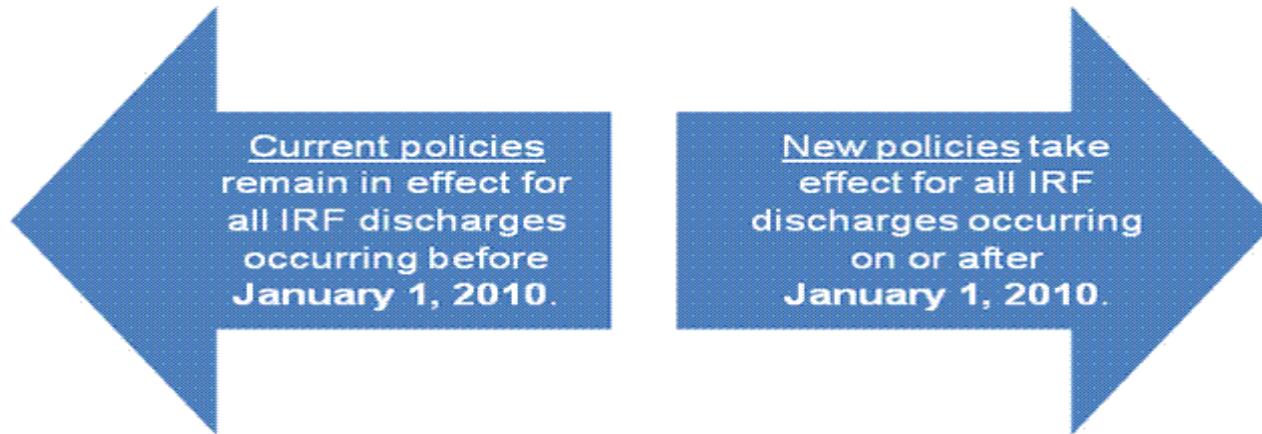
November 2009

Objectives

- Introduce Medicare's new IRF coverage policies.
- **W**alk through some case study examples.
- **F**oster a shared understanding of the policies among all stakeholders.
- **A**nswer any questions you may have about the new policies.



When Do the New Policies Take Effect?

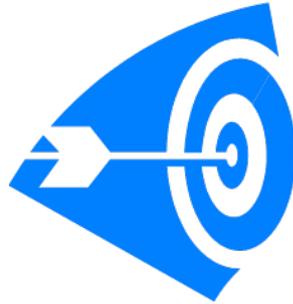


New policies will not be applied retroactively.

Reasons for Updating the Policies

- **C**urrent policies are more than 25 years old.
- **P**olicies were developed prior to the IRF PPS.
- **E**xisting policies do not reflect current medical best practices.
- **E**xisting policies led to differing interpretations among various stakeholders.

Purpose



To provide clear, up-to-date instructions for determining and documenting the medical necessity of IRF admissions.

Policies Developed by CMS Workgroup

- Consisted of general physicians, physiatrists, therapists, and nurses.
- Enlisted the advice of Medical Directors from CMS/HHS, several FIs, QICs, and NIH.
- Stakeholder/industry input through comments on the proposed rule and the IRF Report to Congress.
- Goals:
 - Identify characteristics of patients who require complex rehabilitation in a hospital environment and can most reasonably be expected to benefit from IRF services.
 - Focus on patient characteristics on admission and all services provided during the IRF stay.

Overview of the IRF Benefit

Designed to provide intensive rehabilitation therapy in a resource intensive hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary approach to the delivery of rehabilitation care.

Timing of the IRF Referral

- Patients must be able to fully participate in and benefit from intensive rehabilitation therapy program prior to transfer from the referring hospital.
- IRF claims for patients who are still completing their course of treatment in the referring hospital and cannot tolerate an intensive therapy program **will be denied.**

Patients Appropriate for a Less-Intensive Setting

Patients who have:

- Completed their course of treatment in the referring hospital, but
- Do not require (or cannot participate in or benefit from) an intensive rehabilitation therapy program.



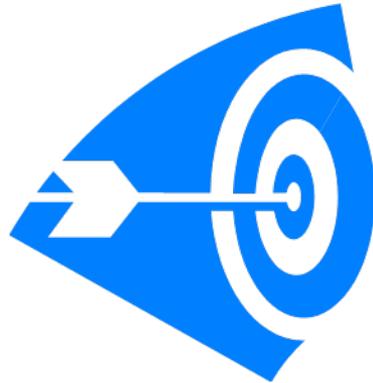
Common Question

How do the new coverage requirements interact with the “60 percent rule”?

Answer:

The new coverage requirements do not affect a facility’s classification as an IRF. Conversely, the new coverage requirements apply equally to all Medicare patients, whether or not the patient is being treated for one or more of the 13 medical conditions listed in the “60 percent rule”.

New Focus of IRF Claims Review



The emphasis is on the admission decision that the IRF can control rather than the patient's rehabilitation trajectory, which may or may not be either predictable or controllable by the IRF. The focus of the review is on the rehabilitation physician's decision-making process in the decision to admit the patient.

Summary of the New Policies

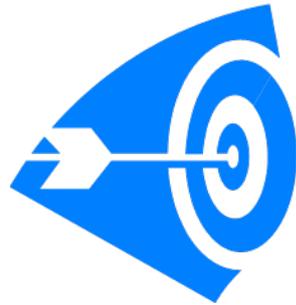
Required Documentation (in the IRF Medical Record) for IRF Admissions to be Considered Reasonable and Necessary:

- Preadmission Screening
- Post-Admission Physician Evaluation
- Individualized Overall Plan of Care
- Physician Orders
- IRF-PAI included in medical record

Criteria for IRF Admissions to be Considered Reasonable and Necessary:

- Multiple Therapy Disciplines
- Intensive Level of Rehabilitation Services
- Ability to Participate in Intensive Therapy Program
- Physician Supervision
- Interdisciplinary Team Approach to Care

Preadmission Screening



A comprehensive preadmission screening process is the key factor in initially identifying appropriate candidates for IRF care.

Key Elements of the Preadmission Screening

Comprehensive and accurate

- Conducted by a licensed or certified clinician or group of clinicians.
- Conducted in person or through a review of the patient's referring hospital medical records (if a hospital stay preceded the IRF admission).
- Includes a detailed and comprehensive review of the patient's condition/medical history.

Timely

- Must be conducted within the 48 hours immediately preceding the IRF admission, or
- Must contain documentation of an update (within the 48 hour time period) if a comprehensive screening containing all of the required elements was conducted more than 48 hours prior to the admission.

Supports the admission decision

- Serves as the initial determination of whether or not the patient meets the requirements for an IRF admission to be considered reasonable and necessary.
- Is used to inform a rehabilitation physician who reviews and documents his or her concurrence with the findings and results of the preadmission screening.
- Is retained in the patient's medical record at the IRF.

Key Information in the Preadmission Screening

- Prior level of function
- Expected level of improvement
- Expected length of time to achieve that level of improvement
- Risk for clinical complications
- Conditions that caused the need for rehabilitation
- Combinations of treatments needed
- Expected frequency and duration of treatment in the IRF
- Anticipated discharge destination
- Any anticipated post-discharge treatments
- Other information relevant to the patient's care needs



Common Question:

Who May Be Involved in the Preadmission Screening Process?

Answer:

A licensed or certified clinician(s) must conduct the preadmission screening. However, the focus of the preadmission screening review should be on the quality of the information supplied and on whether it supports the decision to admit the patient to the IRF, not on the processes (including the personnel) used to collect and compile the information.



Common Question:

When does the rehabilitation physician have to document his or her concurrence with the findings and results of the preadmission screening?

Answer:

After the preadmission screening is completed and prior to the IRF admission.

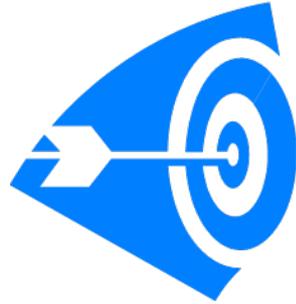
Preadmission Screening Must Support the Admission Decision

The preadmission screening serves as the primary documentation by the IRF clinical staff of:

- the patient's status prior to admission, and
- the specific reasons that led the IRF clinical staff to conclude that the IRF admission would be reasonable and necessary.

Focus of the Medicare contractor's review: Does the reasoning make sense?

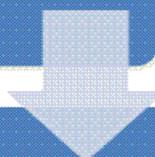
Post-Admission Physician Evaluation



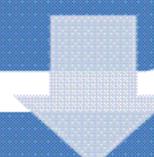
To document the patient's status on admission to the IRF, compare it to that noted in the preadmission screening documentation, and begin development of the patient's expected course of treatment.

Why Require a Post-Admission Physician Evaluation?

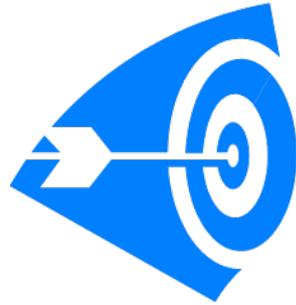
Check whether the patient's status on admission still reflects what was in the preadmission screening (document any changes).



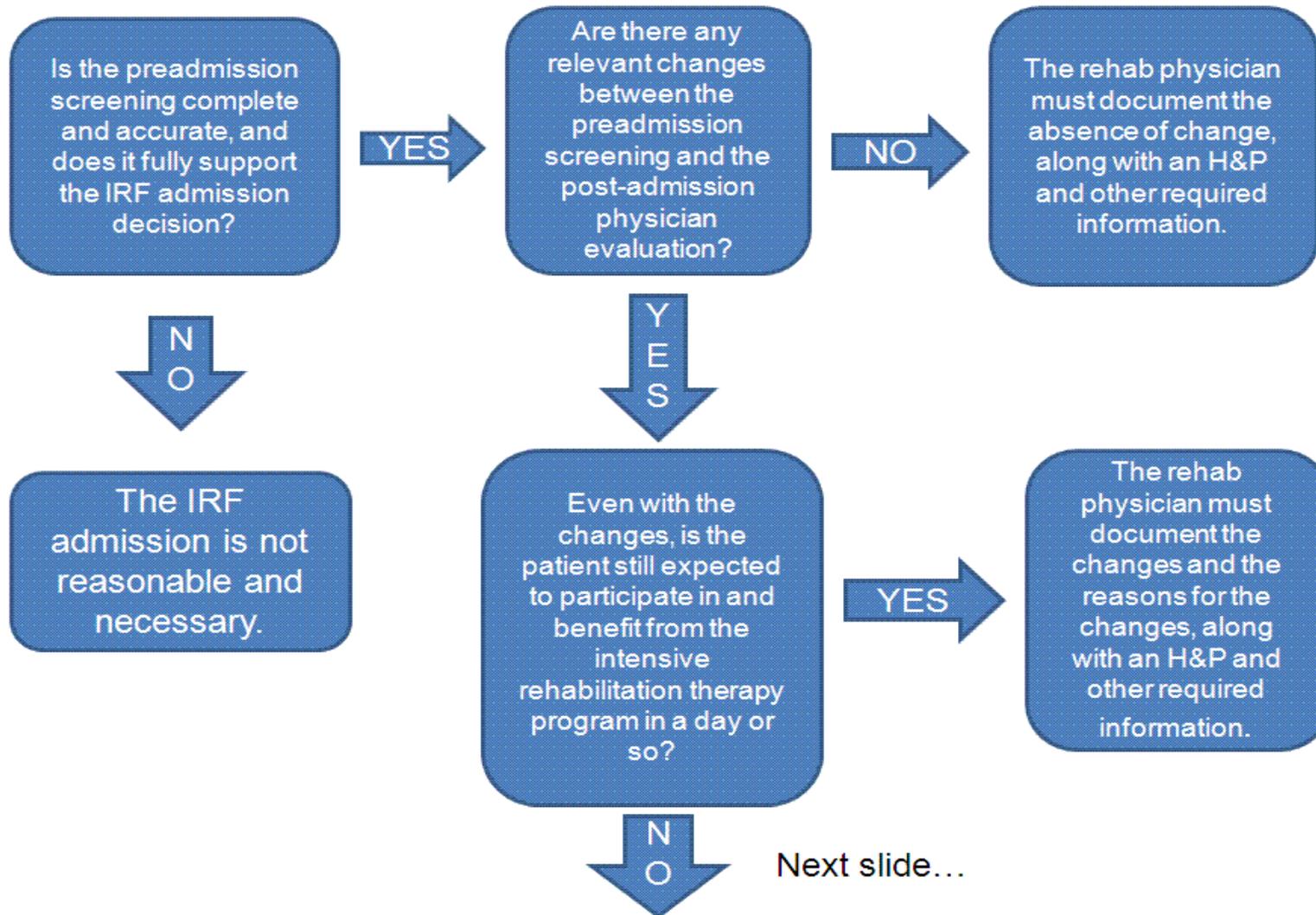
Ensure that a rehabilitation physician sees the patient in the first 24 hours of admission.



Begin development of the patient's expected course of treatment as soon as possible (within 24 hours of admission).



The post-admission physician evaluation must identify any relevant changes that may have occurred since the preadmission screening, and must include a documented history and physical exam, as well as a review of the patient's prior and current medical and functional conditions and comorbidities.



If, on admission, the patient no longer requires, can participate in, or can benefit from an intensive rehabilitation therapy program, the IRF must immediately begin the process of discharging the patient.

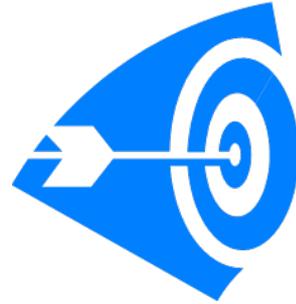


Ideally, the discharge process will take no more than 3 consecutive calendar days.



Even if the discharge process takes longer than 3 days, the IRF will only be eligible to receive the appropriate Medicare payment for IRF stays of 3 days or less.

Individualized Overall Plan of Care



To promote the best possible outcomes for the patient by supporting the need for development of an overall plan of care.

Key Elements of the Overall Plan of Care

Must be **individualized** to the unique care needs of the patient

Is based on:

- Information from the preadmission screen and the post-admission physician evaluation
- Information garnered from therapy assessments

Must be synthesized by a rehabilitation physician

Must be completed within 4 days of the IRF admission

Required Information in the Overall Plan of Care

Estimated length of stay

Medical prognosis

Anticipated interventions, functional outcomes, and discharge destination

Expected therapy

- intensity (# of hours per day) by discipline,
- frequency (# of days per week), and
- duration (total number of days during the IRF stay)



Common Question:

Does the first team meeting have to occur within 4 days to establish the overall plan of care?

Answer:

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.

Admission Orders

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.

New Requirements for the IRF-PAI

The IRF-PAI must be contained in the patient's medical record at the IRF.

The information in the IRF-PAI must correspond with all of the information provided in the patient's IRF medical record.

IRF Medical Necessity Criteria

1. Multiple therapy disciplines
2. Intensive rehabilitation therapy program
3. Ability to participate in therapy program
4. Physician supervision
5. Interdisciplinary team approach to the delivery of care

Criterion #1: Multiple Therapy Disciplines

Bottom line: Patients who only require treatment by one discipline of therapy do not need to be in an IRF.

For this purpose, “therapy disciplines” include:

- Physical therapy
- Occupational therapy
- Speech-language pathology
- Orthotics/prosthetics

Criterion #1: Multiple Therapy Disciplines

One of the therapy disciplines must be physical or occupational therapy, though in most cases both will be needed.

Criterion #2: Intensive Rehabilitation Therapy

Patient must require an intensive rehabilitation therapy program on admission to the IRF.

Not a “rule of thumb.”

Typically demonstrated in IRFs by the provision of therapies:

- At least 3 hours per day at least 5 days per week, or
- An average of at least 15 hours per week—reasons for this must be documented in the medical record.

Initiation of Therapy

- Required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF.
- Therapy evaluations may constitute the initiation of therapy services.
- Therapy evaluations “count” for the purposes of demonstrating the intensity of therapy requirement.

Group Therapies

- The standard of care for IRF patients is individualized (i.e., one-on-one) therapy.
- Group therapies serve as an adjunct to individual therapies.
- Justification for use of group therapies in a particular case should be documented in the patient's medical record at the IRF.

Brief Exceptions to the Intensive Therapy Requirement

Contractors are authorized to grant brief exceptions (not to exceed 3 consecutive days) to the intensity of therapy requirement.

Examples of unexpected clinical events:

- 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



The reasons for the brief interruption in the intensive therapy program must be well-documented in the patient's medical record at the IRF.

Criterion #3: Actively Participate in Intensive Therapy

Patient's condition must be such that there is a reasonable expectation at the time of admission that the patient will be able to actively participate in and benefit from the intensive rehabilitation therapy program provided in an IRF.

Measurable Improvement

Measurable, practical improvement in the patient's functional condition is expected to be accomplished within a predetermined and reasonable period of time.

Measurable Improvement (cont.)

- Generally, the goal of IRF treatment should be the patient's safe return to the home or community-based environment.
- IRF patients do not have to be expected to achieve complete independence in the domain of self-care.
- The IRF medical record must demonstrate that the patient is making functional improvements that are ongoing and sustainable, as well as of practical value, measured against his or her condition at the start of treatment.

Criterion #4: Physician Supervision

Demonstrated by the need for face-to-face visits by a rehabilitation physician or other licensed treating physician with specialized training and experience in rehabilitation **at least 3 days per week** throughout the IRF stay.



Common Question:

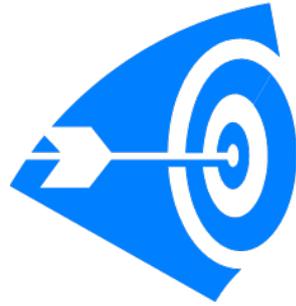
In an inpatient hospital setting, why not require daily (or at least 5 days per week) physician visits?

Answer:

This requirement is specifically to ensure that IRF patients receive more comprehensive assessments of their functional goals and progress (in light of their medical conditions) by a rehabilitation physician with the necessary training and experience to make these assessments at least 3 times per week. Rehabilitation physicians or other physician specialties may treat and visit patients more often, as needed.

Criterion #5: Interdisciplinary Team Approach

The complexity of the patient's nursing, medical management, and rehabilitation needs requires an inpatient stay and an interdisciplinary team approach to care.



The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals.

Required Team Participants

- A rehabilitation physician with specialized training and experience in rehabilitation services;
- A registered nurse with specialized training or experience in rehabilitation;
- A social worker or a case manager (or both);
- A licensed or certified therapist from each therapy discipline involved in treating the patient.

Weekly Team Meetings

Must focus on:

- 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.

Where to Find Information on the New Policies

Regulations—

- FY 2010 IRF PPS final rule (74 FR 39762, pages 39788 through 39798)
- 42 CFR 12.622 (a) (3), (4), and (5)

Manual—

Section 110 of the Medicare Benefit Policy Manual

Internet—

“Coverage Requirements” page on the IRF PPS web site:
http://www.cms.hhs.gov/InpatientRehabFacPPS/04_Coverage.asp

Case Studies

Questions?

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