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Provider Compliance Tips for Inpatient Rehabilitation Facility (IRF)- Inpatient Rehabilitation Hospitals and Inpatient Rehabilitation Units

Provider Types Affected: Physicians and other practitioners who have patients in an IRF who are receiving Part A inpatient services.

Background

The Medicare IRF benefit provides intensive rehabilitation therapy in an inpatient environment, including Inpatient Rehabilitation Hospitals and Inpatient Rehabilitation Units. The IRF benefit is for a beneficiary who requires and can benefit from an inpatient stay and an interdisciplinary approach to rehabilitation care.

According to the [Supplementary Appendices for the Medicare Fee-for-Service \(FFS\) 2015 Improper Payments Report](#), the improper payment rate for Inpatient Rehabilitation Hospitals was 55.7 percent, accounting for a projected \$1.1 billion in Medicare FFS improper payments. Inpatient Rehabilitation Units accounted for a projected \$605 million in Medicare FFS improper payments, with an improper payment rate of 34.4 percent.

Reasons for Denials

The majority of improper payments for IRF services were due to insufficient documentation.

To Prevent Denials

In order for IRF services to be covered under the Medicare IRF benefit, submitted documentation must sufficiently demonstrate that a beneficiary's admission to an IRF was reasonable and necessary, according to Medicare guidelines. Key elements of IRF coverage criteria include a reasonable expectation that at the time of the beneficiary's admission to the IRF the beneficiary:

- Requires the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy)
- Is sufficiently stable and can reasonably be expected to be able to actively participate in, and benefit from, an intensive rehabilitation therapy program
- Requires physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation based on the regulation at 42 CFR 412.622



NOTE: See [42 CFR 412.622](#) for full IRF coverage requirements.

Required documentation elements for an IRF claim include, but are not limited to:

- A comprehensive preadmission screening that is:
 - Conducted by a licensed or certified clinician(s) designated by a rehabilitation physician
 - Completed within the 48 hours immediately preceding the IRF admission
 - A detailed and comprehensive review of each patient's condition and medical history
- A post-admission physician evaluation that is:
 - Conducted by a rehabilitation physician
 - Completed within 24 hours of the patient's admission to the IRF
 - Documentation of the patient's status on admission to the IRF, including a comparison with the information noted in the preadmission screening documentation
- An individualized plan of care that is:
 - Developed by a rehabilitation physician with input from the interdisciplinary team within 5 days of the patient's admission to the IRF
 - Based on the findings of the post-admission physician evaluation
- Admission Orders
- A comprehensive assessment based on guidance in the "Medicare Benefit Policy Manual," Chapter 1, Section 110.1

NOTE: See ["Medicare Benefit Policy Manual," Chapter 1, Section 110.1](#) for further documentation requirements.

Pay particular attention to documenting the patient's need for intensive rehabilitation therapy services requiring care in an IRF. Documentation in the patient's medical record must be accurate and avoid vague or subjective descriptions of the patient's care needs that would not be sufficient to indicate the need for intensive rehabilitation services as described in the "Medicare Benefit Policy Manual," Chapter 1, Section 110.2.

Resources

The following resources provide further information to help you avoid improper payments for IRF services:

For More Information About...	Resource
The Supplemental Appendices for the Medicare Fee-For-Service 2015 Improper Payments Report	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports-Items/Downloads/AppendicesMedicareFee-for-Service2015ImproperPaymentsReport.pdf
“Medicare Benefit Policy Manual,” Chapter 1, Section 110	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf
42 CFR 412.622	https://www.law.cornell.edu/cfr/text/42/412.622

Hyperlink Table

Embedded Hyperlink	Complete URL
Supplementary Appendices for the Medicare Fee-for-Service (FFS) 2015 Improper Payments Report	https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/CERT/CERT-Reports-Items/Downloads/AppendicesMedicareFee-for-Service2015ImproperPaymentsReport.pdf
42 CFR 412.622	https://www.law.cornell.edu/cfr/text/42/412.622
“Medicare Benefit Policy Manual,” Chapter 1, Section 110.1	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf



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