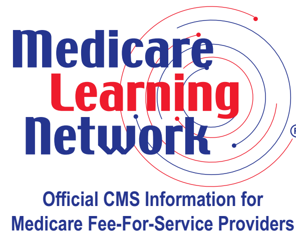
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services



Inpatient Rehabilitation Therapy Services: Complying with Documentation Requirements

This fact sheet describes common Comprehensive Error Rate Testing (CERT) Program errors related to inpatient rehabilitation services and provides information on the documentation needed to support a claim submitted to Medicare for inpatient rehabilitation services.

The Centers for Medicare & Medicaid Services (CMS) developed the CERT Program to produce a national Medicare Fee-For-Service (FFS) improper payment rate, as required by the Improper Payments Information Act of 2002, and the Improper Payments Elimination and Recovery Act of 2010. CERT randomly selects a statistically-valid sample of Medicare FFS claims and reviews those claims and related medical records for compliance with Medicare coverage, payment, coding, and billing rules.

To accurately measure the performance of the Medicare claims processing contractors and to gain insight into the causes of errors, CMS calculates both a national Medicare FFS paid claims improper payment rate and a provider compliance improper payment rate and publishes the results of these reviews annually.

CMS strives to eliminate improper payments in the Medicare Program to maintain the Medicare Trust Fund while protecting patients from medically unnecessary services or supplies.

Common Inpatient Rehabilitation Therapy Services Errors

1. Documentation does not support medical necessity.
2. Missing, incomplete, or illegible signature.
3. Coding errors.

Inpatient Rehabilitation Facility (IRF) Services

IRFs provide intensive rehabilitation services using an interdisciplinary team approach in a hospital environment. Admission to an IRF is appropriate for patients with complex nursing, medical management, and rehabilitative needs.

Medical Necessity at the Time of Admission

Determinations of whether IRF stays are reasonable and necessary must be based on an assessment of each patient's individual care needs. For IRF care to be considered reasonable and necessary, the documentation in the patient's IRF medical record must demonstrate a reasonable expectation that the following criteria were met **at the time of admission** to the IRF. The patient must:

- Require active and ongoing intervention of **multiple therapy disciplines** (Physical Therapy [PT], Occupational Therapy [OT], Speech-Language Pathology [SLP], or prosthetics/orthotics), at least one of which must be PT or OT;
- Require an **intensive rehabilitation therapy program**, generally consisting of:
  - 3 hours of therapy per day at least 5 days per week; or
  - In certain well-documented cases, at least 15 hours of intensive rehabilitation therapy within a 7-consecutive day period, beginning with the date of admission;
- **Reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program** (the patient's condition and functional status are such that the patient can reasonably be expected to make measurable improvement, expected to be made within a prescribed period of time and as a result of the intensive rehabilitation therapy program, that will be of practical value to improve the patient's functional capacity or adaptation to impairments);
- Require **physician supervision by a rehabilitation physician**, with face-to-face visits at least 3 days per week to assess the patient both medically and functionally and to modify the course of treatment as needed; and
- Require an **intensive and coordinated interdisciplinary team approach** to the delivery of rehabilitative care.

Intensive Level of Rehabilitation Services

The information in the patient's IRF medical record must document a reasonable expectation that, at the time of admission to the IRF, the patient generally required the intensive rehabilitation therapy services that are uniquely provided in IRFs. Although the intensity of these services can be reflected in various ways, the generally-accepted standard by which it is typically demonstrated in IRFs is by the provision of intensive therapies at least 3 hours a day for 5 days a week. However, this is not a "rule of thumb," and intensity may also be demonstrated by the provision of 15 hours in a 7-consecutive day period starting from the date of admission, in certain well-documented cases.

NOTE: Therapy minutes cannot be rounded for the purposes of documenting the required intensity.

The patient's IRF medical record must document that the required therapy treatments began within 36 hours from midnight of the day of admission to the IRF. Therapy evaluations done in the IRF constitute initiation of the required therapy services.

The standard of care for IRF patients is one-on-one therapy. Group therapy is acceptable, but must be well-documented and may not constitute the majority of therapy provided to the patient.

NOTE: Time spent in family conferences does **not** count toward intensity of therapy requirements.

While patients requiring an IRF stay are expected to need and receive an intensive rehabilitation therapy program, this may not be true for a limited number of days during a patient's IRF stay because the patient's needs vary over time. If the specific reasons for a break in the provision of therapy services are appropriately documented in the patient's IRF medical record, such a break in service (of limited duration) does not affect the determination of the medical necessity of the IRF admission. Medicare Contractors may approve these brief exceptions.

Interdisciplinary Team Approach to the Delivery of Care

The complexity of the patient's condition must be such that the rehabilitation goals indicated in the preadmission screening, the post-admission physician evaluation, and the overall plan of care can only be achieved through periodic conferences of an interdisciplinary team of medical professionals. The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals.

Team conferences must be held once a week; a week is defined as a 7-consecutive day period, beginning with the date of admission. A regularly-scheduled weekly team conference meets this requirement. At a minimum, the interdisciplinary team must document participation by professionals from each of the following disciplines (each of whom must have current knowledge of the patient as documented in the IRF medical record):

- 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); and
- A licensed or certified therapist from **each** discipline involved in treating the patient.

The weekly interdisciplinary team meeting must be led by a rehabilitation physician who is responsible for making the final decisions regarding the patient's treatment in the IRF. The physician must document concurrence with all decisions made by the interdisciplinary team. Documentation must include the name and professional designation of each interdisciplinary team member in attendance.

The periodic interdisciplinary team conferences must focus on:

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

Measurable Improvement

To justify a continued IRF stay, the documentation in the patient's medical record must demonstrate an ongoing requirement for an intensive level of rehabilitation services and an interdisciplinary team approach to care. The IRF medical record must demonstrate the patient is making functional improvements that are ongoing, sustainable, and of practical value, as measured against the patient's condition at the start of treatment.

Documentation of IRF Services

The patient's medical record at the IRF must contain the following documentation.

Required Preadmission Screening

A preadmission screening is a detailed and comprehensive evaluation of the patient's condition and need for rehabilitation therapy and medical treatment that must be conducted by a licensed or certified clinician(s) (appropriately trained to assess the patient medically and functionally) within the 48 hours immediately preceding the IRF admission. This screening is the initial determination of whether the patient meets the requirements for IRF admission.

If the preadmission screening is completed more than 48 hours prior to admission, there must be a reassessment. The reassessment may be completed by telephone. Any changes from the previous assessment must be documented.

While a physician extender can complete the preadmission screening, the rehabilitation physician must give concurrence that the patient meets the requirements for IRF admission. A rehabilitation physician must review, sign, and date the screening before the patient is admitted to the IRF. The preadmission screening may be completed in person or by telephone (a preadmission screening conducted entirely by telephone will not be accepted without transmission of the patient's medical records from the referring hospital to the IRF and a review of those records by licensed or certified clinical staff in the IRF).

Preadmission screening documentation must justify that the patient requires, will benefit significantly from, and is able to actively participate in intensive rehabilitation therapy. Check-off lists are not acceptable documentation. The preadmission screening documentation must include:

- The specific reasons that led the IRF clinical staff to conclude the IRF admission would be reasonable and necessary;
- The patient's prior level of function;
- The patient's expected level of improvement;
- The expected length of time necessary to achieve the expected level of improvement;
- An evaluation of the patient's risk for clinical complications;
- Treatments needed (OT, PT, SLP, or prosthetics/orthotics);
- The expected frequency and duration of treatment in the IRF;
- The anticipated discharge destination;
- Any anticipated post-discharge treatments; and
- Other information relevant to the care needs of the patient.

Required Post-Admission Physician Evaluation

The purpose of the post-admission physician evaluation is 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 that will be completed with input from all of the interdisciplinary team members in the overall plan of care. A dated, timed, and authenticated post-admission physician evaluation must be retained in the patient's IRF medical record. The post-admission physician evaluation must:

- Be performed by a rehabilitation physician and completed within the first 24 hours after admission to the IRF;
- Support medical necessity of admission;
- Identify any relevant changes that may have occurred since the preadmission screening; and
- Include a documented History and Physical (H&P) exam, as well as a review of prior and current medical and functional conditions and comorbidities.
    - A resident or physician extender (as defined in Section 1861(s)(2)(K) of the Social Security Act [SSA]) can complete the H&P component of the evaluation.
    - If a resident or physician extender completes the H&P, the rehabilitation physician must still visit the patient and complete the other required parts.

If the post-admission physician evaluation does not support the continued appropriateness of the IRF services for the patient, the IRF shall begin the discharge process immediately. Services after the 3rd day will not be considered reasonable and necessary, and the IRF will be paid at the appropriate payment rate for IRF patient stays of 3 days or less.

NOTE: The post-admission physician evaluation may **not** serve as one of the three required rehabilitation physician face-to-face visits in the first week.

Required Individualized Overall Plan of Care

The individualized overall plan of care is synthesized by the rehabilitation physician from the preadmission screening, post-admission physician evaluation, and information garnered from the assessments of all disciplines involved in treating the patient. The individualized overall plan of care must:

- Be completed within the first 4 days of the IRF admission (may be completed at the same time as the post-admission physician evaluation, as long as all required elements are included);
- Support medical necessity of admission;
- Detail the patient's medical prognosis and anticipated interventions (PT, OT, SLP, and prosthetic/orthotic therapies) required during the IRF stay, including:
    - Expected intensity (number of hours per day),
    - Expected frequency (number of days per week), and
    - Expected duration (number of total days during IRF stay);
- Detail functional outcomes; and
- Detail discharge destination from the IRF stay.

Detailed expectations for the course of treatment must be based on consideration of the patient's impairments, functional status, complicating conditions, and any other contributing factors.

Required Admission Orders

Admission orders must be generated by a physician at the time of admission. Any licensed physician may generate the admission order. Physician extenders, working in collaboration with the physician, may also generate the admission order. These admission orders must be retained in the patient's IRF medical record.

Required Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)

The IRF-PAI gathers data to determine the payment for each Medicare Part A FFS patient admitted to an IRF. The IRF-PAI form must be included in the patient's IRF medical record in either electronic or paper format.

Information in the IRF-PAI must correspond with all information in the patient's IRF medical record. The IRF-PAI must be dated, timed, and authenticated in the written or electronic form. 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 is sufficient.

NOTE: You must use the updated IRF-PAI and associated manual instructions for patient assessments performed when a patient is discharged on or after **October 1, 2012**. For the updated form and instructions, visit http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html on the CMS website.

What Do I Need to Know to Prevent Errors?

1. The rehabilitation physician must sign and date the preadmission screening before the patient is admitted to the IRF.
2. Therapy provided in the IRF should be provided primarily one-on-one with a therapist. Use group treatment as an adjunct to the individual treatment when it is well-documented in the patient's medical record that this better meets the patient's needs.
3. Submit claims in accordance with CMS billing instructions for IRFs. For more information, refer to Internet-Only Manual (IOM) Publication (Pub.) 100-04, "Medicare Claims Processing Manual," Chapter 3, Section 140 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c03.pdf on the CMS website.
4. Report the correct patient discharge status code. To obtain a list of all available patient discharge status codes for Medicare claims, refer to Medicare Learning Network® (MLN) Matters® Special Edition Article SE0801, "Clarification of Patient Discharge Status Codes and Hospital Transfer Policies," at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE0801.pdf on the CMS website.

5. Submit the IRF-PAI data collected on a Medicare Part A FFS or Medicare Part C (Medicare Advantage) inpatient to the CMS National Assessment Collection Database by the 27th calendar day (17 days plus a 10-day grace period) from the date of the inpatient's discharge. For more information on the IRF-PAI, visit http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html on the CMS website.

Resources

For more information on Medicare's inpatient rehabilitation therapy services requirements, refer to CMS IOM, Pub. 100-02, "Medicare Benefit Policy Manual," Chapter 1, Section 110 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf on the CMS website.

For more information on IRF coverage requirements, visit http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Coverage.html on the CMS website.

For more IRF updates, refer to the CMS IRF Spotlight web page at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Spotlight.html or the most recent FY Final Rule for the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/List-of-IRF-Federal-Regulations.html on the CMS website.

Quality Reporting

Beginning October 1, 2012, IRFs must submit quality data for the IRF Quality Reporting Program. IRFs that do not comply may still see an increase in annual payments, but, beginning in Fiscal Year (FY) 2014, that increase will be 2 percentage points lower than if they had submitted quality data to the IRF Quality Reporting Program. For more information, visit http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/IRF-Quality-Reporting on the CMS website.

The MLN Educational Web Guides MLN Guided Pathways to Medicare Resources help providers gain knowledge on resources and products related to Medicare and the CMS website. For more information about IRFs, refer to the "Inpatient Rehabilitation Facility" section in the "MLN Guided Pathways to Medicare Resources Provider Specific" booklet at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website. For all other "Guided Pathways" resources, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Guided_Pathways.html on the CMS website.

For more information about provider compliance, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html on the CMS website, or scan the Quick Response (QR) code on the right with your mobile device.

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