



mln call

A MEDICARE LEARNING NETWORK® (MLN) EVENT

IRF-PPS: Overview of Coverage Requirements and Updates from FY 2019 Final Rule

November 15, 2018

Presenters:

Kadie Derby
Catie Kraemer



Acronyms in this Presentation

- CMG: Case-Mix Group
- CoPs: Conditions of Participation
- FIM™: Functional Independence Measure
- IRF: Inpatient Rehabilitation Facility
- IRF-PAI: IRF Patient Assessment Instrument
- PPS: Prospective Payment System



Agenda

- Overview of Inpatient Rehabilitation Facility (IRF) Coverage Requirements
- Overview of Changes Finalized in the FY 2019 IRF Prospective Payment System (PPS) [Final Rule](#):
 - Removal of the Functional Independence Measure (FIM™) and refinements to the Case Mix Classification System
 - Allowing the post-admission physician evaluation to count as one of the three face-to-face visits
 - Updates to the interdisciplinary team meeting
 - Removal of the admission order requirement at 412.606(a)



Overview of IRF Coverage Requirements



Overview of the IRF Benefit

- Designed to provide intensive rehabilitation therapy:
 - In a resource intensive hospital environment
 - For patients who require and can reasonably be expected to benefit from IRF services

Please note: Patients must be able to fully participate in and benefit from intensive rehabilitation therapy program prior to transfer from the referring hospital



Documentation Requirements

- Pre-admission screening
- Post-admission physician evaluation
- Individualized overall plan of care
- IRF Patient Assessment Instrument (PAI) included in the IRF medical record
- Interdisciplinary team notes
- Physician Supervision (3 face-to-face visits per week notes)



Pre-Admission Screening: What is it?

- Preadmission screening:
 - A comprehensive evaluation of the patient's condition to determine if the patient can tolerate and benefit from an intensive rehabilitation therapy regimen and medical treatment provided in an IRF.
 - Serves as the primary documentation of the patient's status prior to admission and documents the specific reasons that led the IRF clinical staff to conclude that the IRF admission was reasonable and necessary.
- Review of the preadmission screening information will focus on its completeness, accuracy, and the extent to which it supports the appropriateness of the IRF admission decision.



Pre-admission Screening: Comprehensive and Accurate

- Conducted by a licensed or certified clinician (or group of clinicians) employed by the IRF
- 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
- Must be retained in the patient's medical record at the IRF



Pre-admission Screening: Personnel

- 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 licensed or certified clinician conducting the preadmission screening has the necessary training, experience, and qualifications in inpatient rehabilitation.



Pre-admission Screening: What Must it Include?

- Must include:
 - 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
- A detailed description must document the conditions/comorbidities the patient has and why these indicate a specific risk for clinical complications that require physician monitoring.
- Licensed or certified clinicians conducting the preadmission screening must write out the detailed reasoning/justification for the IRF admission.



Pre-admission Screening: 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
- Must be signed, dated, and timed by a rehabilitation physician



Pre-admission Screening: Rehabilitation Physician's Concurrence

- The rehabilitation physician must document his or her concurrence with the findings and results of the preadmission screening **after** the preadmission screening is completed and **before** the IRF admission.



Post-Admission Physician Evaluation: What is it?

- The purpose of the post-admission physician evaluation is to document the patient's status on admission to the IRF, compare it to that which is noted in the preadmission screening documentation and begin development of the patient's expected course of treatment.



Post-Admission Physician Evaluation: Who Must Conduct it and by When?

- In order for the IRF stay to be considered reasonable and necessary, the post-admission physician evaluation for all Medicare Part A fee-for-service IRF admissions must:
 - Be completed by the rehabilitation physician
 - Within the first 24 hours of admission to the IRF (including on weekends and holidays)
 - Support the medical necessity of the IRF admission



Post-Admission Physician Evaluation: What Must it Include?

- Any relevant changes that may have occurred since the preadmission screening or a statement that no changes have occurred
- A documented history and physical exam
- A review of the patient's prior and current medical and functional conditions and comorbidities
- Must be dated, timed, and authenticated, in written or electronic form, per the regulations at 482.24(c)(1)



Individualized Overall Plan of Care: What is it?

- The purpose of the overall plan of care is for the rehabilitation physician to gather pertinent information that has been collected regarding the patient's medical and functional treatment needs and goals since the beginning of admission and to synthesize this information into an overall plan of care that will guide the patient's treatment during the IRF stay.
- The overall plan of care must build on information from the preadmission screening and the post-admission physician evaluation. Information garnered from the assessments of all therapy disciplines and other clinicians involved in treating the patient should be taken into consideration as well.



Individualized Overall Plan of Care: Who Must Complete it and by When?

- In order for the IRF stay to be considered reasonable and necessary, the overall plan of care must be completed by the rehabilitation physician by the end of the 4th day (it is completely acceptable to complete on day 1, 2, 3, or 4) of the patient's IRF admission, with the day of admission counting as "day 1"
- While the individual assessments of appropriate clinical staff will contribute to the information contained in the overall plan of care, it is the sole responsibility of the rehabilitation physician to integrate the information that is required in the overall plan of care and to document it in the patient's medical record
- The overall plan of care must support the determination that the IRF admission is reasonable and necessary and must be retained in the patient's medical record at the IRF



Individualized Overall Plan of Care: What Must Be Included?

- The overall plan of care must detail the patient's:
 - Medical prognosis and the anticipated interventions
 - Functional outcomes
 - Expected length of stay in the IRF
 - Discharge destination from the IRF stay
- The anticipated interventions must include:
 - The expected intensity (meaning number of hours per day)
 - Frequency (meaning number of days per week)
 - Duration (meaning the total number of days during the IRF stay) of physician, occupational, speech-language pathology, and prosthetic/orthotic therapies required by the patient during the IRF stay



IRF-PAI

- The IRF-PAI must be dated, timed, and authenticated in written or electronic form and included in the patient's medical record at the IRF.
- The information on the IRF-PAI must correspond with all of the information provided in the patient's IRF medical record.

For additional information on how to complete the IRF-PAI, review our IRF Training Manual on the [IRF-PAI](#) webpage.



IRF PPS - Medical Necessity Criteria

- Multiple therapy disciplines
- Intensive rehabilitation therapy program
- Ability to participate in therapy program
- Physician supervision
- Interdisciplinary team approach to the delivery of care



IRF Medical Necessity Criteria: Multiple Therapy Disciplines

- Patient's who only require treatment by one therapy discipline, do **not** need to be in an IRF
- For this purpose, requirements of active and ongoing therapeutic intervention of “multiple therapy disciplines” including:
 - Physical therapy
 - Occupational therapy
 - Speech-language pathology
 - Orthotics/prosthetics



IRF Medical Necessity Criteria: Intensive Rehabilitation Therapy

- The patient must require an intensive rehabilitation therapy program on admission to the IRF
- Typically demonstrated in IRFs by the provision of therapies: At least 3 hours per day at least 5 days per week

Please note: This is not the only way that such intensity of services can be demonstrated (that is, CMS does not intend for this measure to be used as a “rule of thumb” for determining whether a particular IRF claim is reasonable and necessary)



IRF Medical Necessity Criteria: Intensive Rehabilitation Therapy

- The intensity of therapy services provided in IRFs could also be demonstrated by the provision of 15 hours of therapy per week (that is, in a 7- consecutive day period starting from the date of admission)
 - For example: An IRF patient is admitted for a hip fracture but also undergoing chemotherapy for an unrelated issue. The patient might not be able to tolerate therapy on a predictable basis, 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 to accommodate their chemotherapy schedule.
- Reasons for the patient's need for this program of intensive rehabilitation need to be well-documented in the patient's IRF medical record and the overall amount of therapy can reasonably be expected to benefit the patient.



Intensive Rehabilitation Therapy: Initiation of Therapy

- The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF
 - Example: A patient admitted to the IRF on Friday must start therapy by noon on Sunday
- Therapy evaluations constitute the beginning of the required therapy services
- Therapy evaluations “count” for the purposes of demonstrating the intensity of therapy requirement



Intensive Rehabilitation Therapy: Group Therapies

- The standard of care for IRF patient's is individualized (i.e., one-on-one) therapy
- Group therapies may be used on a limited basis to demonstrate the intensity of therapy requirements only in those rare instances in which group therapy better meets the patient's needs
- The situation/rationale that justifies group therapy should be well-documented and specified in the patient's IRF medical record



Intensive Rehabilitation Therapy: Brief Exceptions Policy

- Contractors are authorized to grant brief exceptions (not to exceed 3 consecutive days) to the intensity of therapy requirement for **unexpected** clinical events 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
- 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

Please note: The brief exceptions policy is not allowed to be used in the first 3 days of the patient's admission



IRF Medical Necessity Criteria: Actively Participate in Intensive Therapy

- The 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 the IRF.



IRF Medical Necessity Criteria: Physician Supervision

- Information in the patient's IRF medical record must document a reasonable expectation that at the time of admission to the IRF, the patient's medical management and rehabilitation needs require an inpatient stay and close physician involvement.
- Close physician involvement in the patient's care is demonstrated by documented face-to-face visits from the rehabilitation physician or other licensed treating physician with specialized training and experience in rehabilitation at least 3 days per week throughout the patient's IRF stay.
- The purpose of the 3 face-to-face visits is to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.
- The rehabilitation physician, other physician specialties, and non-physician practitioners are permitted to visit the patient as often as needed. These visits must be in addition to the minimum required three rehabilitation physician face-to-face visits per week.



IRF Medical Necessity Criteria: Interdisciplinary Team Approach

- Documentation in the patient's IRF medical record must indicate a reasonable expectation that the complexity of the patient's nursing, medical management, and rehabilitation needs require an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation 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 team conferences- at least once a week- of an interdisciplinary team of medical professionals
- Interdisciplinary services are those provided by a treatment team in which all of its members participate in a coordinated effort to benefit the patient and the patient's significant others and caregivers
- The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals



Interdisciplinary Team Approach: Required Participants

At a minimum, the 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 medical record):

- Rehabilitation physician with specialized training and experience in rehabilitation services must lead the meeting
- Registered nurse with specialized training or experience in rehabilitation
- Social worker or a case manager (or both)
- Licensed or certified therapist from each therapy discipline involved in treating the patient



Interdisciplinary Team Approach: Weekly Meetings

- The team conferences— held a minimum of once per week— 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
 - Monitoring and revising the treatment plan, as needed
- Team meeting may be formal or informal; however, a review by the various team members of each other’s notes does not constitute a team conference
- Documentation of each team conference must include the names and professional designations of the participants in the team conference
- All decisions made during such conferences, must be recorded in the patient’s medical record



Overview of Changes Finalized in the FY 2019 IRF PPS Final Rule

Removal of the FIM Instrument from the IRF-PAI

Presented by: Catie Kraemer



Upcoming Changes to the IRF-PAI

- Removal of the FIM Instrument (item 39) and the associated function modifiers (items 29-38):
 - Alleviate Burden
 - Reduce reporting of overlapping information
- Effective October 1, 2019



Incorporation of Quality Indicator Data Items into the IRF PPS

- Data items currently collected in the quality indicators section of the IRF-PAI will be incorporated into the IRF PPS for payment purposes beginning in FY 2020.
- The data items being considered for incorporation into the IRF PPS have been collected since October 1, 2016.



Revisions to the Case-Mix Classification System

- Slight revisions to the IRF case-mix classification system are necessary to reflect the use of the data items from the quality indicator section of the IRF-PAI in the IRF PPS
- Revisions include:
 - Changes to the motor and cognitive function scores
 - Changes to the Case-Mix Groups (CMGs)
- [Technical Report](#): Analyses to Inform the Potential Use of Standardized Patient Assessment Data Elements in the Inpatient Rehabilitation Facility Prospective Payment System



Ongoing Analysis

- As finalized in the FY 2019 IRF PPS final rule, we will incorporate two years of data into our analysis to revise the CMG definitions
- Revisions to the CMGs will be addressed in future rule making prior to October 1, 2019



Overview of Changes Finalized in the FY 2019 IRF PPS Final Rule

Changes Related to the Coverage Criteria

Presented by: Kadie Derby



Changes to the Physician Supervision Requirement

- Beginning with FY 2019 (IRF discharges beginning on or after October 1, 2018), the post-admission physician evaluation may count as one of the three weekly face-to-face physician visits
- There are **no** changes to the 24-hour timeframe within which the post-admission physician evaluation requirement must be completed



Changes to the Interdisciplinary Team Meeting Requirement

- Beginning with FY 2019 (IRF discharges beginning on or after October 1, 2018), rehabilitation physicians may lead the interdisciplinary team meeting remotely without any additional documentation requirements
- This change does not apply to any other staff required to attend the interdisciplinary team meeting
- This policy change in no way precludes IRFs from exercising their own discretion in determining how best to organize their medical staff or implementing a protocol for determining when the rehabilitation physician should lead the meeting in person or remotely



Changes to the Admission Order Documentation Requirement

- Beginning with FY 2019 (IRF discharges beginning on or after October 1, 2018), the admission order documentation requirement at 412.606(a) has been removed
- Admission Orders should continue to be appropriately documented in accordance with 482.12(c) and 482.24(c) of the hospital Conditions of Participation (CoPs), as well as the hospital admission order payment requirements at 412.3
- IRFs are responsible for meeting all of the inpatient hospital CoPs and the hospital admission order payment requirements



Question & Answer Session



Resources

- For IRF Medicare policy questions, contact IRFcoverage@cms.hhs.gov
- For additional information, visit the [IRF PPS](#) website
- [OIG Report](#)



Thank You – Please Evaluate Your Experience

Share your thoughts to help us improve – [Evaluate](#) today's event

Visit:

- [MLN Events](#) webpage for more information on our conference call and webcast presentations
- [Medicare Learning Network](#) homepage for other free educational materials for health care professionals

The Medicare Learning Network® and MLN Connects® are registered trademarks of the U.S. Department of Health and Human Services (HHS).



Disclaimer

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

