

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 119	Date: January 15, 2010
	Change Request 6699

Transmittal 112, issued on October 23, 2009, is being rescinded and replaced with Transmittal 119. Sections 110.3.1 through 110.5 are being deleted from the manual as this information was updated and incorporated into sections 110 through 110.3. All other information remains the same.

Subject: Coverage of Inpatient Rehabilitation Services

I. SUMMARY OF CHANGES: This Change Request replaces the existing instructions in chapter 1, section 110 that describes coverage for inpatient rehabilitation services provided in inpatient rehabilitation facilities. These new instructions are supported by recent regulatory changes that can be found in 42 C.F.R. Section 412.622 (FR 74, 39762 (August 7, 2009)).

New / Revised Material

Effective Date: For IRF discharges occurring on or after January 1, 2010

Implementation Date: January 4, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED

R/N/D	Chapter/Section/Subsection/Title
R	1/110/ Inpatient Rehabilitation Facility (IRF) Services
R	1/110/110.1/ Documentation Requirements
N	1/110/110.1.1/Required Preadmission Screening
N	1/110/110.1.2/Required Post-Admission Physician Evaluation
N	1/110/110.1.3/Required Individualized Overall Plan of Care
N	1/110/110.1.4/Required Admission Orders
N	1/110/110.1.5/Required Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)
R	1/110/110.2/Inpatient Rehabilitation Facility Medical Necessity Criteria
R	1/110/110.2.1/Multiple Therapy Disciplines

N	1/110/110.2.2/Intensive Level of Rehabilitation Services
N	1/110/110.2.3/Ability to Actively Participate in Intensive Rehabilitation Therapy Program
N	1/110/110.2.4/Physician Supervision
N	1/110/110.2.5/Interdisciplinary Team Approach to the Delivery of Care
R	1/110/110.3/Definition of Measurable Improvement
D	1/110/110.3.1/General
D	1/110/110.3.2/Specific Examples
D	1/110/110.4/Rehabilitation Hospital Screening Criteria
D	1/110/110.4.1/Close Medical Supervision by a Physician With Specialized Training or Experience in Rehabilitation
D	1/110/110.4.2/Twenty-Four Hour Rehabilitation Nursing
D	1/110/110.4.3/Relatively Intense Level of Rehabilitation Services
D	1/110/110.4.4/Multi-Disciplinary Team Approach to Delivery of Program
D	1/110/110.4.5/Coordinated Program of Care
D	1/110/110.4.6/Significant Practical Improvement
D	1/110/110.4.7/Realistic Goals
D	1/110/110.5/Length of Rehabilitation Program

III. FUNDING:

SECTION A: For Fiscal Intermediaries and Carriers:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

SECTION B: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-02	Transmittal: 119	Date: January 15, 2010	Change Request: 6699
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Transmittal 112, issued on October 23, 2009, is being rescinded and replaced with Transmittal 119. Sections 110.3.1 through 110.5 are being deleted from the manual as this information was updated and incorporated into sections 110 through 110.3. All other information remains the same.

SUBJECT: Coverage of Inpatient Rehabilitation Services

Effective Date: For IRF discharges occurring on or after January 1, 2010

Implementation Date: January 4, 2010

I. GENERAL INFORMATION

A. Background: In the FY 2010 final rule (74 FR 39762 (August 7, 2009)) CMS adopted new inpatient rehabilitation facility (IRF) coverage requirements and technical revisions to certain other IRF requirements to reflect changes that have occurred in medical practice during the past 25 years and the implementation of the IRF PPS. In light of adopting new coverage requirements that will be effective for IRF discharges occurring on or after January 1, 2010, a Notice has been issued to rescind HCFAR 85-2 when the new coverage requirements take effect. Pub 100-02, Medicare Benefit Policy Manual, chapter 1, section 110 was originally based upon the provisions found in HCFAR 85-2. Therefore, the purpose of this Change Request is to issue new instructions to replace the existing instructions found in section 110 consistent with the new IRF coverage requirements adopted in the FY 2010 final rule.

B. Policy: The new IRF coverage requirements that form the basis for the new instructions in Pub. 100-02, chapter 1, section 110, are found in 42 C.F.R. §412.622(a)(3), (a)(4), and (a)(5). Under the new coverage policy, the decision to admit the patient to the IRF is the key to determining whether the admission is reasonable and necessary. Thus, these manual revisions include the following subjects: Documentation Requirements; Required Preadmission Screening; Required Post-Admission Physician Evaluation; Required Individualized Overall Plan of Care; Required Admission Orders; Required Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI); Inpatient Rehabilitation Facility Medical Necessity Criteria; Multiple Therapy Disciplines; Intensive Level of Rehabilitation Services; Ability to Actively Participate in Intensive Rehabilitation Therapy Program; Physician Supervision; Interdisciplinary Team Approach to the Delivery of Care; and Definition of Measurable Improvement.

Effective with IRF discharges on and after January 1, 2010, contractors must use the updated coverage policy in the medical review of IRF claims. Contractor training is being scheduled for November 2, 2009. Instructions on how to sign up for the training will be issued shortly.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)								
		A / B M A C	D M E M A C	F I	C A R R I E R	R H I	Shared-System Maintainers			
						F I S S	M C S	V M S	C W F	
6699.1	The contractor shall discontinue use of the existing instructions for coverage of inpatient hospital stays for	X		X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	rehabilitation care found in Pub 100-02, Medicare Benefit Policy Manual, chapter 1, §110 effective for discharges occurring on or after January 1, 2010.										
6699.2	The contractor shall begin using the new instructions for coverage in Inpatient Rehabilitation Facilities found in Pub 100-02, Medicare Benefit Policy Manual, chapter 1, §110 for discharges occurring on or after January 1, 2010.	X		X							
6699.3	The contractor shall update its existing medical review policies and procedures for coverage of inpatient hospital stays for rehabilitation care based upon the new instructions for coverage in inpatient rehabilitation facilities found in Pub 100-02, Medicare Benefit Policy Manual, chapter 1, §110 for discharges occurring on or after January 1, 2010.	X		X							
6699.4	The contractor shall update its existing local coverage determinations (LCD's) 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, §110 for discharges occurring on or after January 1, 2010.	X		X							
6699.4.1	The contractor shall advise IRFs that its existing local coverage determination policy applicable to inpatient hospital stays for rehabilitation care is no longer effective with discharges occurring on and after January 1, 2010.	X		X							
6699.5	The contractor shall designate at least one member of its medical review department to participate in the CMS training to be provided via teleconference scheduled in November 2009. This individual shall act as a resource during the review/update of the contractor's medical review policies and procedures	X		X							

II. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
6699.6	Contractors shall post this entire instruction, or a direct link to this instruction, on their Web site and include information about it in a listserv message within 1 week of the release of this instruction. In addition, the entire	X		X							

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	instruction must be included in your next regularly scheduled bulletin. Contractors are free to supplement it with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

N/A

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
N/A	

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Julie Stankivic (410) 786-5725

Post-Implementation Contact(s): Susanne Seagrave (410) 786-0044

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs)*, *Regional Home Health Intermediaries (RHHIs)*, and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: For *Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Benefit Policy Manual

Chapter 1 - Inpatient Hospital Services Covered Under Part A

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110 - Inpatient Rehabilitation Facility (IRF) Services

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

The inpatient rehabilitation facility (IRF) benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient 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 team approach to the delivery of rehabilitation care.

The IRF benefit is not to be used as an alternative to completion of the full course of treatment in the referring hospital. A patient who has not yet completed the full course of treatment in the referring hospital is expected to remain in the referring hospital, with appropriate rehabilitative treatment provided, until such time as the patient has completed the full course of treatment. Though medical management can be performed in an IRF, patients must be able to fully participate in and benefit from the intensive rehabilitation therapy program provided in IRFs in order to be transferred to an IRF. IRF admissions for patients who are still completing their course of treatment in the referring hospital and who therefore are not able to participate in and benefit from the intensive rehabilitation therapy services provided in IRFs will not be considered reasonable and necessary.

Conversely, the IRF benefit is not appropriate for patients who have completed their full course of treatment in the referring hospital, but do not require intensive rehabilitation. Medicare benefits are available for such patients in a less-intensive setting.

IRF care is only considered by Medicare to be reasonable and necessary under 1862(a)(1)(A) of the Social Security Act if the patient meets all of the requirements outlined in 42 CFR §§412.622(a)(3), (4), and (5), as interpreted in this section. This is true regardless of whether the patient is treated in the IRF for 1 or more of the 13 medical conditions listed in 42 CFR §412.23(b)(2)(ii) or not. Medicare requires determinations of whether IRF stays are reasonable and necessary to be based on an assessment of each beneficiary's individual care needs.

For detailed guidance on the required qualifications of a therapist, required skills of a therapist, and medically necessary and appropriately documented therapy services, 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.

110.1 – Documentation Requirements

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

Medicare contractors must consider the documentation contained in a patient's IRF medical record when determining whether an IRF admission was reasonable and

necessary, specifically focusing on the preadmission screening, the post-admission physician evaluation, the overall plan of care, and the admission orders.

110.1.1 – Required Preadmission Screening

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

A preadmission screening is an evaluation of the patient's condition and need for rehabilitation therapy and medical treatment that must be conducted by licensed or certified clinician(s) within the 48 hours immediately preceding the IRF admission. A preadmission screening that includes all of the required elements, but that is conducted more than 48 hours immediately preceding the IRF admission, will be accepted as long as an update is conducted in person or by telephone to document the patient's medical and functional status within the 48 hours immediately preceding the IRF admission in the patient's medical record at the IRF. The preadmission screening in the patient's IRF medical record serves as the primary documentation by the IRF clinical staff of the patient's status prior to admission and of the specific reasons that led the IRF clinical staff to conclude that the IRF admission would be reasonable and necessary. As such, IRFs must make this documentation detailed and comprehensive.

The preadmission screening documentation must indicate the patient's prior level of function (prior to the event or condition that led to the patient's need for intensive rehabilitation therapy), expected level of improvement, and the expected length of time necessary to achieve that level of improvement. It must also include an evaluation of the patient's risk for clinical complications, the conditions that caused the need for rehabilitation, the treatments needed (i.e., physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), expected frequency and duration of treatment in the IRF, anticipated discharge destination, any anticipated post-discharge treatments, and other information relevant to the care needs of the patient.

If the patient is being transferred from a referring hospital, the preadmission screening may be done in person or through a review of the patient's medical records from the referring hospital (either paper or electronic format), as long as those medical records contain the necessary assessments to make a reasonable determination. However, 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.

The IRF is responsible for developing a thorough preadmission screening process for patients admitted to the IRF from the home or community-based environment, which is expected to include all of the required elements described in this section. However, such admissions may not necessarily involve the use of medical records from a prior hospital stay in another inpatient hospital setting unless such records are pertinent to the individual patient's situation.

Individual elements of the preadmission screening may be evaluated by any clinician or group of clinicians designated by a rehabilitation physician, as long as the clinicians are licensed or certified and qualified to perform the evaluation within their scopes of practice and training. 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.

The “rehabilitation physician” need not be a salaried employee of the IRF but must be a licensed physician with specialized training and experience in rehabilitation. For ease of exposition throughout this document, this physician will be referred to as a “rehabilitation physician”.

All findings of the preadmission screening must be conveyed to a rehabilitation physician prior to the IRF admission. In addition, the rehabilitation physician must document that he or she has reviewed and concurs with the findings and results of the preadmission screening prior to the IRF admission.

All preadmission screening documentation (including documents transmitted from the referring hospital or other prior inpatient hospital stay, if applicable) must be retained in the patient’s medical record at the IRF.

“Trial” IRF admissions, during which patients were sometimes admitted to IRFs for 3 to 10 days to assess whether the patients would benefit significantly from treatment in the IRF or other settings, are no longer considered reasonable and necessary. Such determination must be made through a careful preadmission screening prior to the patient’s admission to the IRF.

110.1.2 – Required Post-Admission Physician Evaluation

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

A post-admission physician evaluation of the patient must be performed by a rehabilitation physician. 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 (as discussed in section 110.1.3). 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.

In order for the IRF stay to be considered reasonable and necessary, the post-admission

physician evaluation must be completed within the first 24 hours of admission to the IRF and must support the medical necessity of the IRF admission. The post-admission physician evaluation documentation must be retained in the patient's medical record at the IRF.

What to do if there are differences between the preadmission screening and the post-admission physician evaluation (within the first 24 hours of admission to the IRF):

In most cases, the clinical picture of the patient that emerges from the post-admission physician evaluation will closely resemble the information documented in the preadmission screening. However, for a variety of reasons, the patient's condition at the time of admission may occasionally not match the description of the patient's condition on the preadmission screening. This could occur, for example, if the patient's condition changes after the preadmission screening is completed. In these cases, it is important for a rehabilitation physician to note the discrepancy and to document any deviations from the preadmission screening as a result. For example, if the patient's preadmission screening indicated an expectation that the patient would actively participate in an intensive rehabilitation therapy program on admission to the IRF, but the patient is only able to tolerate a less intensive therapy program on the first day due to an increase in pain secondary to a long ambulance trip to the IRF, the IRF does not have to discharge the patient since the clinicians fully expect the patient to be able to participate in the intensive rehabilitation program the next day. Instead, the reason for the temporary change must be noted in the patient's medical record at the IRF.

In addition, the preadmission screening and the post-admission physician evaluation could differ in rare cases when a patient's preadmission screening indicates that the patient is an appropriate candidate for IRF care but this turns out not to be the case, either, for example, due to a marked improvement in the patient's functional ability since the time of the preadmission screening or an inability to meet the demands of the IRF rehabilitation program. If this occurs, the IRF must immediately begin the process of discharging the patient to another setting of care. It might take a day or more for the IRF to find placement for the patient in another setting of care. Medicare contractors will therefore allow the patient to continue to receive treatment in the IRF until placement in another setting can be found. However, in these particular cases, any IRF services provided after the 3rd day following the patient's admission to the IRF (considering the day of admission to be the 1st day) are not considered reasonable and necessary. In these particular cases, instead of denying the entire IRF claim for not meeting the criteria in section 110.2 of this chapter, Medicare authorizes its contractors to permit the IRF claim to be paid at the appropriate case mix group (CMG) for IRF patient stays of 3 days or less.

110.1.3 – Required Individualized Overall Plan of Care

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

Information from the preadmission screening and the post-admission physician

evaluation, together with other information garnered from the assessments of all therapy disciplines involved in treating the patient and other pertinent clinicians, will be synthesized by a rehabilitation physician to support a documented overall plan of care, including an estimated length of stay. The overall plan of care must detail the patient's medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRF stay, thereby supporting the medical necessity of the admission. The anticipated interventions detailed in the overall plan of care must include the expected intensity (meaning number of hours per day), frequency (meaning number of days per week), and duration (meaning the total number of days during the IRF stay) of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies required by the patient during the IRF stay. These expectations for the patient's course of treatment must be based on consideration of the patient's impairments, functional status, complicating conditions, and any other contributing factors.

Whereas 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 a 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 at the IRF.

In the unlikely event that the patient's actual length of stay and/or the expected intensity, frequency, and duration of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies in the IRF differ significantly from the expectations indicated in the overall plan of care, then the reasons for the discrepancies must be documented in detail in the patient's medical record at the IRF.

In order for the IRF admission to be considered reasonable and necessary, the overall plan of care must be completed within the first 4 days of the IRF admission; it must support the determination that the IRF admission is reasonable and necessary; and it must be retained in the patient's medical record at the IRF.

While CMS believes that it may be good practice to conduct the first interdisciplinary team meeting within the first 4 days of admission to develop the overall individualized plan of care, CMS believes that there may be other ways of developing the overall individualized plan of care. Thus, IRFs may develop this required documentation using whatever internal processes they believe are most appropriate.

110.1.4 – Required Admission Orders

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

At the time that each Medicare Part A fee-for-service patient is admitted to an IRF, a physician must generate admission orders for the patient's care. These admission orders must be retained in the patient's medical record at the IRF.

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

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

Medicare now requires that the IRF patient assessment instrument (IRF-PAI) forms be included in the patient's medical record at the IRF (either in electronic or paper format). The information in the IRF-PAIs must correspond with all of the information provided in the patient's IRF medical record.

110.2 - Inpatient Rehabilitation Facility Medical Necessity Criteria

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

In order for IRF care to be considered reasonable and necessary, the documentation in the patient's IRF medical record (which must include the preadmission screening described in section 110.1.1, the post-admission physician evaluation described in section 110.1.2, the overall plan of care described in section 110.1.3, and the admission orders described in section 110.1.4) must demonstrate a reasonable expectation that the following criteria were met at the time of admission to the IRF:

- 1. The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy.*
- 2. The patient must generally require an intensive rehabilitation therapy program, as defined in section 110.2.2. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF.*
- 3. The patient must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program that is defined in section 110.2.2 at the time of admission to the IRF. The patient can only be expected to benefit significantly from the intensive rehabilitation therapy program if the patient's condition and functional status are such that the patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the patient's functional capacity or adaptation to impairments) as a result of the rehabilitation treatment, as defined in section 110.3, and if such improvement can be expected to be made within a prescribed period of time.*
- 4. The patient must require physician supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week*

throughout the patient's stay in the IRF 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.

- 5. The patient must require an intensive and coordinated interdisciplinary approach to providing rehabilitation, as defined in section 110.2.5.*

110.2.1 – Multiple Therapy Disciplines

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

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. For this reason, the information in the patient's IRF medical record (especially the required documentation described in section 110.1) must document a reasonable expectation that, at the time of admission to the IRF, the patient required the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy.

110.2.2 – Intensive Level of Rehabilitation Services

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

A primary distinction between the IRF environment and other rehabilitation settings is the intensity of rehabilitation therapy services provided in an IRF. For this reason, the information in the patient's IRF medical record (especially the required documentation described in section 110.1) 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 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 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).

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, 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. Thus, IRFs may also demonstrate a patient's need for intensive rehabilitation therapy services by showing that the patient required and could reasonably be expected to benefit from at least 15 hours of therapy per week (defined as a 7-consecutive day period starting from the date of admission), as long as the reasons for the patient's need for this program of intensive rehabilitation are well-documented in the patient's IRF medical record and the overall amount of therapy can reasonably be expected to benefit the patient. Many IRF patients will medically benefit from more than 3 hours of therapy per day or more than

15 hours of therapy per week, when all types of therapy are considered. However, the intensity of therapy provided must be reasonable and necessary under section 1862(a)(1)(A) of the Act and must never exceed the patient's level of need or tolerance, or compromise the patient's safety. See below for a brief exceptions policy for temporary and unexpected events.

The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF. Therapy evaluations constitute the beginning of the required therapy services. As such, they are included in the total daily/weekly provision of therapies used to demonstrate the intensity of therapy services provided in an IRF.

The standard of care for IRF patients is individualized (i.e., one-on-one) therapy. Group therapies serve as an adjunct to individual therapies. In those instances in which group therapy better meets the patient's needs on a limited basis, the situation/rationale that justifies group therapy should be specified in the patient's medical record at the IRF.

Brief Exceptions Policy—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.

110.2.3 – Ability to Actively Participate in Intensive Rehabilitation Therapy Program

(Rev. 119, Issued: 01-15-10; Effective Date: For IRF discharges occurring on or after January 1, 2010; Implementation Date: 01-04-10)

The information in the patient's IRF medical record (especially the required documentation described in section 110.1) must document a reasonable expectation that at the time of admission to the IRF the patient's condition is such that the patient can reasonably be expected to actively participate in, and significantly benefit from, the intensive rehabilitation therapy program that is defined in section 110.2.2.

110.2.4 – Physician Supervision

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A primary distinction between the IRF environment and other rehabilitation settings is the high level of physician supervision that accompanies the provision of intensive rehabilitation therapy services. For this reason, the information in the patient's IRF medical record (especially the required documentation described in section 110.1) 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 a 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 face-to-face visits is to assess the patient both medically and functionally (with an emphasis on the important interactions between the patient's medical and functional goals and progress), as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. Other physician specialties may treat and visit the patient, as needed, more often than 3 days per week. However, the requirement for IRF physician supervision is intended 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. The required rehabilitation physician visits must be documented in the patient's medical record at the IRF.

110.2.5 – Interdisciplinary Team Approach to the Delivery of Care

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An IRF stay will only be considered reasonable and necessary if at the time of admission to the IRF the documentation in the patient's IRF medical record indicates a reasonable expectation that the complexity of the patient's nursing, medical management, and rehabilitation needs requires an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care. That is, 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 (as defined below).

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. Interdisciplinary services, by definition, cannot be provided by only one discipline. Though individual members of the interdisciplinary team work within their own scopes of practice, each professional is also expected to coordinate his or her efforts with team members of other specialties, as well as with 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.

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 medical record at the IRF):

- 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 therapy discipline involved in treating the patient.*

The interdisciplinary team must be led by a rehabilitation physician who is responsible for making the final decisions regarding the patient's treatment in the IRF. This physician must document concurrence with all decisions made by the interdisciplinary team at each meeting.

The periodic 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; and*
- Monitoring and revising the treatment plan, as needed.*

A team conference may be formal or informal; however, a review by the various team members of each other's notes does not constitute a team conference. It is expected that all treating professionals from the required disciplines will be at every meeting or, in the infrequent case of an absence, be represented by another person of the same discipline who has current knowledge of the patient. 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. The focus of the review of this requirement will be on the accuracy and quality of the information and decision-making, not on the internal processes used by the IRF in conducting the team conferences.

110.3 – Definition of Measurable Improvement

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A patient can only be expected to benefit significantly from an intensive rehabilitation therapy program provided in an IRF, as required in section 110.2.3, if the patient's IRF medical record indicates a reasonable expectation that a measurable, practical improvement in the patient's functional condition can be accomplished within a predetermined and reasonable period of time. 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 patient's IRF medical record is expected to indicate both the nature and degree of expected improvement and the expected length of time to achieve the improvement.

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.

For an IRF stay to be considered reasonable and necessary, the patient does not have to be expected to achieve complete independence in the domain of self-care. However, to justify the need for a continued IRF stay, the documentation in the IRF medical record must demonstrate the patient's ongoing requirement for an intensive level of rehabilitation services (as defined in section 110.2.1) and an inter-disciplinary team approach to care (as defined in Section 110.2.2). Further, the IRF medical record must also demonstrate that the patient is making functional improvements that are ongoing and sustainable, as well as of practical value, measured against his/her condition at the start of treatment. Since in most instances the goal of an IRF stay is to enable a patient's safe return to the home or community-based environment upon discharge, the patient's treatment goals and achievements during an IRF admission are expected to reflect significant and timely progress toward this end result. During most IRF stays, therefore, the emphasis of therapies would generally shift from traditional, patient-centered therapeutic services to patient/caregiver education, durable medical equipment training, and other similar therapies that prepare the patient for a safe discharge to the home or community-based environment.