IRF Payment and Coverage Policies: FY 2019 Final Rule Call

Moderated by: Joanna Pahl and Leah Nguyen
November 15, 2018 1:30pm

Table of Contents

Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen-only mode until the question and answer session.

This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. I will now turn the call over to Joanna Pahl. Thank you. You may begin.

Announcements & Introduction

Joanna Pahl: Hi. I'm Joanna Pahl from the Provider Communications Group here at CMS and I will be moderating your call today. I would like to welcome you to this Medicare Learning Network call on Inpatient Rehabilitation Facility or IRF Prospective Payment System.

During this call, learn about changes finalized in the fiscal year 2019 final rules including revisions to coverage criteria, removal of the functional independent measure and associated function modifiers from the IRF patient assessment instrument, refinement to the case mix classification.

Before we get started, you received a link to the presentation in your confirmation email. The presentation is available at the following URL.

Leah Nguyen: go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

Leah Nguyen: Today's event is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in, but please refrain from asking questions during the question and answer session.

If you have inquiries, contact press@cms.hhs.gov. At this time, I would like to turn the call over to Todd Smith from the Chronic Care Policy Group.

Presentation

Todd Smith: Thank you, Joanna. Good afternoon, everybody, and good morning to those on the west coast and welcome to the call. My name is Todd Smith. I'm the director of the Division of Institutional Post-Acute Care.

And with me in the room is Susanne Seagrave. She is the Deputy Director of the Division of Institutional Post-Acute Care. And I'm also joined by Kadie Derby and Catie Kraemer. They are team members of the IRF team.

And one of our main – one of the issues that we deal with in the division, we are responsible for the development and implementation of the payment policies associated with the IRF PPS in this call, the overview of the coverage requirements and updates from the FY 2019 final rule.

One – I just wanted to go over really quickly before we get into the – Kadie and Catie get into the slides. There are a couple of reasons why we are here today to talk about this call. Some of you may be aware recently the OIG published a report. The title of this report is Many Inpatient Rehab Facilities Still Do Not Meet Coverage and Documentation Requirements.

This is an audit that was done based on more recent audits that were performed by the OIG and investigated due to some of the increases in the error rate and looking into how IRFs comply within the CMS coverage requirement.

One of those recommendations in the report is to provide further education for IRFs regarding the IRF coverage requirements. And Kadie Derby is going to go over some of those coverage requirements today.

In addition, as I rewind this note, as a part of the agency's initiative with the Patients Over Paperwork initiatives, we're soliciting comments, request for information through previous rules, and through the – through those – through that solicitation, we finalized the number of policies to remove provider burden and Catie Kraemer will be going through those issues today.

I also want to note, in addition to this call today, you can always reach us with questions about IRF coverage requirements or changes that we finalized through this year's rule by contacting us through the resource mailbox. And the resource mailbox is irfcoverage@cms.hhs.gov. With that, I'll turn it over to Kadie Derby.

Kadie Derby: Thanks, Todd. I just wanted to take a moment and echo what Todd said and thank all of you for joining us this afternoon. We are hopeful that today's presentation will serve as a helpful educational tool as well as provide any clarification needed about our most recent finalized updates.

Before we begin, I would like to take a moment to make an announcement and that is we now plan to have at least one representative from the IRF Payment Policy team, attend each hospital Open Door Forum moving forward.

We've heard from providers that it would be helpful to have an IRF representative on the calls to answer any payment policy related questions that might come up. So, we are certainly happy and available to do so.

We plan to use the ODF as a platform to give IRF providers any updates that we might have regarding payment policy, and as I mentioned, to answer any questions regarding payment policy that we can.

So, with that, I supposed we'll get started with today's presentation. If you are following along with the slide presentation that we have provided, we'll go ahead and get started with the agenda on slide 3.

The purpose of today's call is to provide a brief overview of the current IRF coverage requirements as well as an overview of the changes finalized in the fiscal year 2019 IRF PPS final rule that published August 6, 2018.

Overview of IRF Coverage Requirements

We can go ahead and skip slide 4 and move on to slide 5. The 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.

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

Slide 6, the documentation in the patient's IRF medical record must contain the following – the pre-admission screening, the post-admission physician evaluation, an individualized plan of care, the IRF PAI, any interdisciplinary team notes, and physician supervision notes from the required face-to-face visits. Over the next few slides, we'll discuss each documentation requirement individually and what is necessary to meet it.

Slide 7, the pre-admission screening is an 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.

The pre-admission screening 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.

As noted, at the bottom of the slide, review of the pre-admission screening information by MACs will focus on its completeness, accuracy, and the extent to which it supports the IRFs admission decision.

Slide 8, the pre-admission screening must be comprehensive and accurate. It must be conducted by a licensed or certified clinician or group of clinicians employed by the IRF. It must be conducted in person or through a review of the patient's referring hospital medical records.

If a hospital stay perceived the IRF admission, it must include a detailed and comprehensive review of the patient's condition and medical history. And lastly, it must be retained in the patient's medical record at the IRF.

Every now and then, we'll get a question of whether or not CMS plans to create a standard pre-admission screening document for IRF to utilize. The answer to that is no. We believe that each IRF should retain the flexibility to determine the best way to meet the pre-admission screening requirements. And for that reason, we have no plans to provide a standard form.

We do suggest though that for the ease of reviewers trying to locate the pre-admission screening information in the patient's medical record, providers should document all required elements in one document titled, Pre-admission Screening.

Slide 9, 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 – 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 pre-admission screening has the necessary training, experience, and qualifications in inpatient rehabilitation.

Slide 10. On this slide, we have listed what must be included in the pre-admission screening documentation. I won't read through them one by one. But in order for the pre-admission screening to be considered complete and thorough, all bullet points must be included in the pre-admission screening documentation.

Slide 11, the timeliness of the pre-admission screening. The pre-admission screening must be conducted within the 48 hours preceding – 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. And lastly, it must be signed, dated and timed by the rehabilitation physician.

Slide 12, the rehabilitation physician's concurrence with the pre-admission screening. The rehabilitation physician must document his or her concurrence with the findings and results of the pre-admission screening after the pre-admission screening is completed and before the IRF admission.

I will also note that we will not accept a rehabilitation physician's review and concurrence after the patient is admitted to the IRF. Additionally, it is not acceptable for the rehabilitation physician to indicate his or her review and concurrence verbally by telephone or for another clinician, such as an admission liaison to document the review and concurrence for the rehabilitation physician.

Slide 13, moving on to the post-admission physician evaluation. Let's first discuss what the purpose of this actually is. The purpose of the post-admission physician evaluation is to document the patient status on admission to the IRF, compare it to that, which is noted in the pre-admission screening documentation, and begin development of the patient's expected course of treatment.

Slide 14, 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 documented by the rehabilitation physician within the first 24 hours of admission to the IRF and that includes weekends and holidays and support the medical necessity of the IRF admission.

Slide 15, what must it include? Any relevant changes that may have occurred since the pre-admission 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, and it must be dated, timed and authenticated per the regulations at 482.24c1.

Slide 16, the individualized overall plan of care. 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 pre-admission 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.

We emphasized the word individualized in the context of the overall plan of care because each overall plan of care must be tailored to the unique care needs of each IRF patient.

Slide 17, the individualized overall plan of care must be completed by the rehabilitation physician by the end of the fourth day with admission counting as day 1. It is the sole responsibility of the rehabilitation physician to complete the individualized overall plan of care. We do expect that assessments from appropriate staff will contribute to the information.

However, the rehabilitation physician must integrate it accordingly. As always, the plan of care must support the determination that the admission was reasonable and necessary and must be retained in the patient's IRF medical record.

Slide 18, the following slide outlines what should be included in the patient's individualized overall plan of care in order for it to be considered a complete document.

Slide 19, this slide should be pretty straight forward regarding the requirements of the IRF-PAI. The IRF-PAI must be dated, timed and authenticated and included in the patient's IRF medical record.

Additionally, all information on the IRF-PAI must correspond with all of the information in the patient's medical record. If you have additional questions regarding how to complete the IRF-PAI, please refer to the IRF-PAI training manual, which is linked on this slide.

Slide 20. In order for the IRF stay 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 requires multiple therapy disciplines. The patient requires an intensive rehabilitation therapy program. The patient is able to participate in the therapy program. The patient requires physician supervision and an interdisciplinary team approach to the delivery of care.

Slide 21, the patient must require the active and ongoing therapeutic intervention of multiple therapy discipline to include physical therapy, occupational therapy, speech language pathology, or prosthetics and orthotics, one of which must be physical or occupational therapy.

If the patient only requires treatment by one therapy discipline, they do not need IRF level services.

Slide 22. As the slide states, a patient must require an intensive rehabilitation therapy program on admission to the IRF.

The way in which intensive rehab therapy is usually demonstrated in IRF is at least three hours of therapy per day at least five 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, quote/unquote, "rule of thumb," for determining whether a particular IRF claim is reasonable and necessary.

Slide 23. The provision of therapy can also be demonstrated by conducting 15 hours of therapy per week. A week is described as a seven consecutive day period beginning with the day of admission.

For clarification, we have provided an example on this slide of what that may look like. Please keep in mind that reasons for the patient's needs for this type of therapy program must be thoroughly documented in the medical record and that the patient is expected to benefit from the overall amount of therapy.

Slide 24, the initiation of therapy. The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF. An example of that is a patient admitted to the IRF on Friday, they must start therapy by noon on Sunday.

Therapy evaluations constitutes the beginning of the required therapy services. And lastly, therapy evaluations do count for the purposes of demonstrating the intensity of therapy requirements.

Slide 25, group therapies. The standard of care for IRF patients 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.

Slide 26, the brief exceptions policy. We understand that in some instances unexpected clinical events may occur during the patient's stay that limits the patient's ability not to exceed three consecutive days to participate in their therapy program.

In this situation, contractors are authorized to grant brief exceptions to the intensity of therapy requirements for unexpected clinical events if they determine that the initial expectation was that the patient was actively able to participate in intensive therapy regimen.

If these reasons are appropriately documented in the patient's IRF medical record, such a break in service will not affect the determination of the medical necessity of the IRF admission. Please note that the brief exceptions policy is not allowed to be used in the first three days of the patient's admission.

Slide 27. The patient must 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 an IRF.

Slide 28, 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's medical management and rehabilitation needs require an inpatient stay and close physician involvement.

Close physician involvement is demonstrated by documented face-to-face visit at least three days per week throughout the patient's IRF stay. The purpose of this face-to-face visit 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.

Other physician specialties may treat and visit the patient as needed more often than three 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 by a rehabilitation physician with the

necessary training and experience to make these assessments at least three times per week. These required visits must be documented in the patient's IRF medical record.

Slide 29, an interdisciplinary team approach. Documentation in the patient's medical record must indicate a reasonable expectation that the patient's 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 can only be achieved through periodic team conferences at least once a week 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. Additionally, all members of the team must participate in a coordinated effort to benefit the patient.

Slide 30, required participants of the interdisciplinary team. 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.

The rehabilitation physician with specialized training and experience in rehabilitation services must lead the meeting, a registered nurse with specialized training or experience in rehabilitation, a social worker or a case worker or both, and a licensed or certified therapist from each therapy discipline involved in treating the patient.

Slide 31, the weekly team meeting must be held once a week and must include the bulleted information we have outlined on this slide. The team meeting may be formal or informal. However, simply reviewing the team members' notes will not fulfill the requirement.

The names of all participants must be documented, and all decisions made during the meeting must be recorded in the patient's IRF medical record.

That concludes the brief overview of the coverage criteria portion of this presentation. I'll now hand it over to my colleague, Catie Kraemer, so she can update you on the finalized changes regarding the removal of the FIM from the IRF-PAI.

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

Catie Kraemer: Thank you, Kadie. I'll be giving a brief overview of upcoming changes to the IRF-PAI and revisions to the IRF case mixed classification system beginning on slide 33.

In the fiscal year 2019, IRF PPS final rule, CMS finalized the removal of the FIM instrument and the associated function modifiers from the IRF-PAI beginning on October 1, 2019 to reduce administrative burden and to eliminate the reporting of overlapping information.

Several data items that are currently collected on the IRF-PAI to support the IRF QRP capture data that overlapped with data collected through other legacy items on the assessment. We finalized the removal of these

legacy items to reduce burden associated with collecting and reporting similar information. This change is effective for fiscal year 2020.

Slide 34. The data items that are being removed from the IRF-PAI are currently used to assign patients to CMGs for payment purposes under the IRF PPS. These items will no longer be available. After October 1, 2019, we will begin using the items collected in the Quality Indicator section of the assessment for this purpose.

I would like to note that the data items being considered for incorporation in the IRF PPS had been collected on the IRF PAI since October 1, 2016. There will not be any new items added to the assessment to support this change. The only change in the assessment is the removal of 11 data items.

Moving on to slide 35. The items that will be incorporated into the IRF PPS captures similar but slightly differing information and utilize a different scale from the items that are currently used for payment purposes. This is necessitated minor revisions to the IRF Case-Mix classification system so that IRF PPS payments can be calculated correctly using these items.

These revisions include changes to the motor and cognitive function scores that are used to assign a patient to a CMG for payment purposes as well as changes to the CMGs. A combination of data items from the Quality Indicator section of the assessment will be used to derive the functional scores used to assign patients to a CMG.

Additionally, the CMGs will be revised to reflect these items. This may result in some IRFs having more CMGs and other IRFs having fewer CMGs.

More information on how these items will be incorporated into the IRF Case-Mix system is available at the technical report that accompanied the fiscal year 2019 IRF PPS final rule. This report can be accessed from the CMS IRF PPS website or from the link on the slide.

Slide 36. Based on the comments received on our original proposal to revise the CMGs and as finalized in the fiscal year '19 IRF PPS final rule, we are incorporating 2 years of data into our analysis to revise the CMG definition using the Quality Indicator data items.

We will use both fiscal year 2017 and fiscal year 2018 data to complete our analysis. We will present any changes to the CMGs in future rulemaking prior to October 1, 2019. Thank you.

I will now turn the presentation back to Kadie Derby.

Kadie Derby: Thanks, Catie. Moving on to slide 38. Beginning with fiscal year 2019, that is 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.

Up until we finalize this change, rehabilitation physicians were required to see the patient four times in the first week of the patient's admission, once to complete post-admission physician evaluation and three additional times to satisfy the physician supervision requirement of face-to-face visit.
Our finalized change simply allows the post-admission physician evaluation to count as one of the required face-to-face visits. Therefore, beginning October 1, 2018, rehabilitation physicians are now able to see the patient

three times in the 1st week of the patient's admission, once for the post-admission physician evaluation and 2 additional times for the face-to-face required visits.

There are no documentation requirement changes. You will continue to document the post-admission physician evaluation and the face-to-face visit as you always have. Lastly, there are no changes in the 24-hour timeframe, at which the post-admission physician evaluation must be completed.

Slide 39, changes to the interdisciplinary team meeting requirements. Beginning with fiscal year 2019, that is 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 interdisciplinary team meeting.

This policy change in no way precludes IRF from exercising their own discretion in determining how to best organize their medical staff or implementing a protocol for determining when the rehabilitation physician should lead the meeting in person or remotely.

Slide 40, changes to the admission order documentation requirement. Beginning with fiscal year 2019, that is IRF discharges beginning on or after – on or after October 1, 2018, the admission order documentation requirement at 412.606a has been removed.

Admission orders should continue to be appropriately documented in accordance with 482.12c and 482.24c of the hospital conditions of participation 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.

Frequently Asked Questions

That concludes the presentation portion of today's call. Before we open up the phone lines for your questions, we'd like to take a brief moment to answer some of the frequently asked questions that we receive during the registration process for today's call.

Question 1, is an IRF admission order still required for IRF payment given the recent changes in this year's final rule? The answer to that question is yes.

Our removing the IRF admission requirement at 412.606a was simply to remove a duplicative requirement. As we have mentioned, IRFs are responsible for meeting the hospital CoPs of participation at 482.12c and 482.24c and the hospital payment requirement at 412.3.

In the fiscal year 2019, IPPS LTCH final rules, CMS revised the language in 412.3 that discusses for purposes of Part A payment. Admission orders are required to be signed and documented in the medical record prior to discharge. This revision was proposed because there were documented instances where the medical review officials were using this language to deny otherwise medically reasonable and necessary Part A claims.

With this change, the process will refocus the medical review efforts to determining whether the care and services provided were reasonable and necessary rather than whether the order itself was valid and adhered to this requirement.

In summary, the responsibilities of providers regarding inpatient admission orders is unchanged as IRFs are responsible for meeting hospital CoPs as well as hospital payment requirements. What has changed is one of the consequences, namely the denial of an individual claim for the full reason of failure to meet this former condition of payments.

Question 2, will the physician need to provide any additional documentation beyond what is usually included in the post-admission physician evaluation to permit the post-admission physician evaluation to count as one of the face-to-face visits?

I was sure to answer this question very thoroughly in the presentation and the answer is no. There are no documentation changes to how the rehabilitation physician currently documents the post-admission physician evaluation and how they document the face-to-face visits.

Question 3, given the physician will not be present at the team meeting, what should the physician do to document their remote attendance?

Just to be clear, this policy change in no way precludes IRF 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. That being said, there is no need for the physician to document their remote attendance. That is the entire premise of our finalized change.

Question 4, to what extent can a student therapist be involved in the delivery of therapy services when those students are being – when those services are being counted to satisfy the intensity of therapy requirements?

Therapy student minutes may not be counted as part of the intensive rehabilitation therapy program provided in an IRF. The Medicare conditions of participation for – participation for hospitals at 482.56 require that only qualified physical therapist, physical therapy assistant, occupational therapist, occupational therapy assistant, speech language pathologist, or audiologist are as defined in Part 484 of 42 CFR can provide therapy services to patients in hospitals including IRF.

The personnel qualifications required in Part 484 all specify graduation from an accredited training program. Students do not meet this standard.

And lastly, question 5 that I'll be going over before I hand it back over to Catie Kraemer.

In the 2019 IPPS LTCH final rule, CMS requires hospitals to post a list of their standard charges on the Internet in a machine-readable format. Does this apply to IRF? And if so, what standard IRF charges should be posted and in what format?

Yes. As IRFs are considered hospital, this requirement applies to IRF. As the rule states, each hospital operating within the United States shall for each year establish and update and make public in accordance with guidelines developed by the secretary a list of the hospital standard charges for items and services provided by the hospital.

For additional questions regarding this policy as we will not be fielding questions regarding this today, please direct your questions to hospital_odf as in frank @cms.hhs.gov.

Catie Kraemer: Thank you, Kadie. We also received a few questions that are outside the scope of today's call. Unfortunately, we will not be able to address questions about the IRF QRP or questions regarding IRF coding instructions for clinically assessing patients on this call.

We encourage anyone that has questions about completing items on the assessment to make use of the existing IRF resources, including the clinical help line or mailbox.

Also, any questions regarding IRF QRP can be addressed through the existing IRF QRP resource mailbox. The contact information of both the clinical help line and email resource mailbox is available on the CMS IRF PPS website. Thank you. I will now turn the call back to Joanna.

Question & Answer Session

Leah Nguyen: Thank you, Catie. We will now take your questions. As a reminder, this event is being recorded and transcribed. In an effort to get to as many of your questions as possible, each caller is limited to one question.

To allow more participants the opportunity to ask questions, please send questions specific to your organization to the resource mailbox on slide 42 so our staff can do more research.

Preference will be given to general questions applicable to a larger audience and we will be mindful of the time spent on each question.

All right, Dorothy. We're ready for our first caller.

Operator: To ask a question, press star followed by the number one on your touchtone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to assure clarity.

Once your line is open, state your name and organization. Please note, your line will remain open during the time you were asking your question, so anything you say or any background noise will be heard in the conference.
If you have more than one question, press star one to get back into the queue and we will address additional questions as time permits. Please hold while we compile the Q&A roster.

Please hold while we compile the Q&A roster.

Your first question comes from the line of Heather Kieren.

Heather Kieren: Hi. This is Heather Kieren from Northern Lighthouse. I'm just wondering if you could clarify that student piece that you just went over, does that include students that have direct supervision by their supervising therapist that are also signing off on their notes?

Kadie Derby Does it?

Leah Nguyen:Hold on a moment.

Heather Kieren: Okay.

Susanne Seagrave: Hi. This is Susanne. So, Kadie read the conditions of participations that apply to IRFs. So, there is no – therapy students are not one of the personnel that are allowed to provide therapy in an IRF setting. That's what the conditions of participation say.

Leah Nguyen: Thank you.

Heather Kieren: Okay.

Operator: Your next question comes from the line of Mary Kate Stanford.

Mary Kate Stanford: Hi. This is Mary Kate Stanford. I was AAP at Menar. And my question has to do with some of the information you were giving on the different slides. There are at least 2 that I noticed and probably others that got right by me where some of the requirements you are listing are not listed in the manual or in the regulations at least as far as I could tell.

The first one was the one about for the pre-admission review. It must be done by an employee of the rehab institute. I can't find that anywhere in the regulation. How would we know that?

Joanna Pahl: Thank you. Can you hold one moment please?

Mary Kate Stanford: Sure.

Susanne Seagrave: So, hi. This is Susanne. I mean who else would be doing the pre-admission screening but an employee of the IRF.

Mary Kate Stanford: Well, they might get somebody from the acute care hospital to do part of it.

Susanne Seagrave: No, that – we consider that a conflict of interest.

Mary Kate Stanford: Okay. Well, they could hire somebody that just goes out and does it?

Susanne Seagrave: Well, then they're an employee of the IRF.

Mary Kate Stanford: Well, they are a contractor.

Todd Smith: Employed by the IRF.

Susanne Seagrave: But they're still being paid by the IRF.

Mary Kate Stanford: So, by employed you mean just that they're paid by the IRF because they – if it's a contractor, that is not an employee because they just have a contract to go out and fulfill certain task.

Susanne Seagrave: Okay. Well, I don't want to – this question sounds a little bit beyond the scope of what we can discuss here. So, maybe we can take it offline and you can send that question to the IRF coverage mailbox that we gave you the address for.

Leah Nguyen: And it's listed on slide 42.

Mary Kate Stanford: Okay. And then the other one that I noticed was the exception where the – it's said that the exception was not available during the first three days. Again, I didn't see the anywhere previously. I saw that it can be no more than three consecutive days, but it didn't say anything that it could be within the first three days.

Kadie Derby: Hi. Can you please also send that to the IRF coverage mailbox and we'll get back to you.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Renee Thorsbold.

Renee Thorsbold: Hi. This is Renee Thorsbold from the Ohio State University Wexner Medical Center. My question relates to slide 23. Just to clarify, intensity of therapy services for a patient who is participating in therapy for 15 hours of therapy over 7 days.

Does the therapy have to start on day 1 or does the timeframe for meeting this criteria start on day 1? For example, could a patient who arrives late in the afternoon on the day of admission receive 15 hours of therapy over days 2, through, 7, and still meet this criteria?

Kadie Derby: Yes. That would meet the criteria of this requirement.

Renee Thorsbold: Thank you.

Kadie Derbie: Sure.

Operator: Your next question comes from the line of Sharon Feldman.
Sharon Feldman: Hi. This is Sharon Feldman from Froedtert Hospital in Milwaukee. I'm just wondering when we will see the new CMGs based on the new IRF-PAI or where?

Kadie Derby: As we said, those – any revisions to the CMGs that were – we published a sort of a draft of the CMGs in the – in these FY 2019 final rule for IRF PPS that was published on, I believe, August 6, 2018. That was a draft version.

Now, we're going to go back and do the analysis as soon as we have the FY 2018 data available and the revised CMGs to the extent that there are any revisions – revised CMGs will be put through notice and comment rulemaking prior to the October 1, 2019 implementation date.

Joanna Pahl: Thank you.

Operator: Your next question comes from the line of Jan Oliver.

Jan Oliver: Hi. My name is Jan Oliver calling from Salt Lake City. I have a question about the post-admission physician evaluation. In a facility where the inpatient rehab facility and acute care are co-located, can the evaluation be done on acute care by the medical resident if the documentation is transcribed after IRF admission and attested to by the physiatrist?

Kadie Derby: No. It needs to be completed by the rehabilitation physician of the IRF. That would not meet our requirements.

Jan Oliver: So, the claim would be denied even if the services were otherwise medically necessary?

Kadie Derby: That doesn't meet our requirements. It needs to be the rehabilitation physician of the IRF.

Jan Oliver: After admission, not on acute care, correct?

Kadie Derby: After admission, correct.

Jan Oliver: Perfect. Okay. Thank you so much. I appreciate that.

Joanna Pahl: Thank you.

Operator: Your next question comes from the line of Lia Allen.

Lia Allen: Yes. Hi. I have a question about the pre-admission screen and the personnel who are qualified to do that. Can you clarify what a certified clinician would be? Hello?

Kadie Derby: So, we address this on slide 9. It's the responsibility of the IRF and the rehabilitation physician to ensure that a licensed or certified clinician conducting the pre-admission screening has the necessary training, experience, and qualifications in inpatient rehabilitation.

Lia Allen: Yes. I did read that. I just wonder if you can tell me what a certified – an example of a certified clinician would be, if someone gets a certification …

Susanne Seagrave: Well, the reason that …
Lia Allen: If someone gets a certification in – like a clinical liaison certification that's available through some vendors, is that considered as certified clinician who has – someone who has a – otherwise has a clinical background?

Susanne Seagrave: Well, first of all, the licensure and certification of clinicians is typically a state-by-state law thing. So, we can't necessarily clarify that because it's going to differ state-by-state.

But we have provided information about what the person's – the individual's licensure or certification must enable them to do. And so, we have a list. They must be able to assess the patient both medically and functionally, et cetera. I don't have that list in front of me.

But the clarification is that in order for a certification or a licensure to be used for this purpose the individual clinician must – that particular licensure or certification must enable them to perform the functions that they have to perform for the pre-admission screening and those are all listed in the manual, and Kadie gave them earlier. So, if that helps.

Lia Allen: They're in the benefits policy manual?

Susanne Seagrave: Yes. Chapter 1 Section 110 of the Benefit Policy Manual.

Lia Allen: Okay. Thank you.

Joanna Pahl: Thank you.

Operator: As a reminder, if you would like to ask a question, please press star then the number one on your telephone keypad. Your next question comes from the line of David Thompson.

Unidentified Female: Hi. Our question is about the CMG and payment-based after the removal of the FIM between that interim and the new payment system in 2020. How are we paid if the FIM is removed?

Leah Nguyen: Hold on a moment.

Susanne Seagrave: Hi. This is Susanne. You will continue to be paid the way you have been using the FIM items in the payment determination until October 1, 2019. October 1, 2019, it will switch over to the revised CMGs using the new quality – using the Quality Indicators items.

Joanna Pahl: Thank you.

Operator: Your next question comes from the line of Carol Sim.

Carol Sim: Good afternoon. This is Carol Sim, the CEO at Siskin Rehabilitation Hospital in Tennessee. Can you please provide some more guidance such as scenario examples for capturing a patient's usual performance in the new system?

Catie Kraemer: We will be providing more training on the Section GG items in the future. However, if anyone has any questions currently, please reach out to the IRF clinical health line to address those questions.

Joanna Pahl: Thank you.

Operator: Your next question comes from the line of Marybeth Foley.

Marybeth Foley: My question was just answered. Thank you.

Joanna Pahl: Thank you.

Operator: Your next question comes from the line of Jim Palucci.

Jim Palucci: Yes. Good afternoon. Just I wanted to have a clarification on the first question about students because we do have students. They have one-on-one supervision from a CI and they do write the notes, but it's co-signed with their clinical instructors. So, I just wanted to make sure that's the provision of – accepted provision of treatment to the patients?

Susan Seagrave: Again, the hospital conditions of participation that we noted that apply to IRF as they do any hospital indicates that this therapy provided in that setting needs to be provided by a licensed therapist or therapy assistant, it cannot be provided by a student.

Jim Palucci: If the student participates but it is provided by the licensed therapist, I guess that's my question. Because I'm trying to advocate for the students having clinical rotations in IRF-PAI. That's how they learn. So, I just wanted to make sure we still are able to take students.

Susanne Seagrave: The therapy must be provided by a licensed therapist or therapy assistant.

Joanna Pahl: Thank you.

Operator: Your next question comes from the line of Sandra Estrada.

Sandra Estrada: Hi. This is Sandra Estrada from Thomas Rehab Hospital. Our question was on the team conference, the required participants. Would a PTA be allowed to report? Hello?

Joanna Pahl: Could you please repeat your question?

Sandra Estrada: For the team conference, one of the participants, would that be – would a PTA be able to participate and report on their patients?

Kadie Derby: No. It must be the – I'm thinking that you're saying PTA, physical therapy assistant. It must be the physical therapist. It cannot be the assistant.

Sandra Estrada: Okay. Yes. Thank you.

Kadie Derby: Sure. Thank you.

Operator: Your next question comes from the line of Andrew Baird.

Andrew Baird: Good afternoon. This is Andre Baird from Encompass Health. Thank you for taking the time to do an independent dedicated IRF Open Door Forum. I know this is one of the first ones.

So, I appreciate it. My question is more procedural in nature. In terms of just the timing of this going forward, do you all anticipate having this regularly or periodically or as needed? Just wondering sort of what the expectation can be from our side, and thanks again.

Kadie Derby: Hi. Thanks for your question. We did just want to clarify that this is actually not an IRF Open Door Forum. This is a National Provider call just for IRF providers. What I mentioned at the very beginning of the presentation was that we are now participating in the hospital Open Door Forum.

And I think that they occur once every six weeks. We don't have an agenda for it right now. So, we would have to get back to you. But just to clarify, we're not starting a solo Open Door Forum just for IRFs. We will now be participating on the hospital Open Door Forum calls.

Andrew Beard: Got it. Thank you.

Kadie Derby: Sure.

Operator: Your next question comes from the line of Karen Packet.

Karen Packet: Hi. This is Karen Packet from Spalding Rehab. We have – and I wanted to know if you could explain your plan to better involve stakeholders in the development of the revised CMGs for fiscal year 2020?

Joanna Pahl: Could you give us one moment please?

Karen Packet: Sure.

Catie Kraemer: As noted in the rule, we're going to prepare these changes through a notice in comment rulemaking. So, we will use that opportunity to solicit feedbacks from IRF stakeholders.

Karen Packet: Okay

Joanna Pahl: Thank you.

Operator: Your next question comes from the line of Maggie Gaynor.
Maggie Gaynor: Hi. This is Maggie Gaynor from Twin Falls, Idaho. And I have a couple of questions. One of them is on slide 31 and it says documentation of each team conference must include the names and professional designations of the participants in the team conference.

Does that mean that we can just list their names, or do we need a signature from each of the participants in the medical record?

Kadie Derby: Thanks for your question. This is Kadie Derby. No. It doesn't need to be individual signatures from each participant, just a list of names and professional designations.

Maggie Gaynor: Okay. My second question is our physician generally rounds on the patient before they admit to the unit and dictates his post-admission evaluation at that time prior to admission. Is that allowed, or does he need to wait until after the patient is physically on the unit?

Kadie Derby: That actually does not meet our requirements. The post-admission physician evaluation is to be done after the patient is admitted to the IRF so that they can compare their clinical status as they were during the pre-admission screening.

Maggie Gaynor: Okay. Thank you.

Operator: Your next question comes from the line of Elena Schmidt.

Sherene Davis: Hi. This is Sherene Davis from Centera and we have a couple of questions, just a clarification on – I believe somebody asked about therapy assistants like a COTA or a PTA. You're stating that they cannot participate in team conference?

Kadie Derby: No. We're not saying that they can't participate at all. They can certainly be involved. We have no issues with that. But they can't be the sole primary representative of that therapy discipline.

The licensed therapist needs to be there. So, they can certainly participate as well, but they can't be representative of the physical therapy discipline or occupational therapy discipline, et cetera.

Joanna Pahl: Thank you.

Sherene Davis: Is this a new – sorry. Is this a new rule?

Kadie Derby: No. We actually have this stated in our clarifications if you visit the IRF website.

Sherene Davis: Okay.

Joanna Pahl: Thank you. As a reminder, if you have more than one question, you can press star one to get back into the queue. And we will address additional questions as time permits.

Operator: Your next question comes from the line of Jane Snecinski.

Jane Snecinski: Hi, there. My name is Jane Snecinski and I'm president of Post-Acute Advisors. And I have a question pertaining to slide number 7. Many organizations – many IRFs are admitting patients who have received minimal therapy in acute care.

So, in order to meet this particular coverage guideline, I'm wondering if this is a physician's statement stating that based on his professional expertise even though the patient hasn't received multiple disciplines due to their condition they need multiple disciplines if that will meet this coverage guidelines?

Susanne Seagrave: Yes. Yes. The simple answer is yes. We – the whole purpose of many of these documentation requirement is for the rehabilitation physician who has the necessary expertise and training in

these issues to be able to tell us things like that, like what you just said that based on their professional judgment and this patient's clinical conditions and comorbidities, et cetera, that this patient would benefit from multiple therapy disciplines, yes.

Jane Snecinski: Perfect. Thank you so much.

Operator: Your next question comes from the line of Barbara Lillwitz.

Carol Colin: Hi. Good morning or good afternoon. Thank you for taking my call. My question – and this is Carol Colin. I'm with inaudible with Barbara. My question has to do with the physician order. Does that need to be ordered prior to the time of admission or can I see within the hour of admission and what's the requirement on that?

Kadie Derby: Can you actually do us a favor and send that to our IRF coverage mailbox?

Carol Colin: Sure.

Kadie Derby: Great. Thank you.

Operator: Your next question comes from the line of Julie Price.

Anne: My name is Anne and I'm from Cottage Rehabilitation Hospital. My question has to also do with students. I understand if the therapist is there directly supervising the student. You stated that that will not count towards – the minutes won't count towards the three-hour rule. Is this correct?

Susanne Seagrave: Thi is Susanne. Yes. That's correct. The conditions of participation say that if rehabilitation therapy is provided in a hospital, such as an IRF, then it must be provided by a licensed therapist or therapy assistant.

Anne: So, if they're collaboratively working, any time the student touches the patient, those minutes don't count towards the three-hour rule. Is that correct?

Susanne Seagrave: Yes. Thank you.

Anne: And then if any documentation is co-signed by the supervising therapist, those minutes would not count?

Susanne Seagrave: Again, the condition of participation say that if rehabilitation therapy is provided in a hospital setting, such as an IRF, it must be provided by a licensed therapist or therapy assistant. That is the regulation.

Operator: Your next question comes from the line of Joan Ranza.

Joan Ranza: Yes. Thank you. I have a question about the physician signing the screen – the pre-admission screen. If he has Internet incapability, are we allowed to override, and he can do it manually when he is back in the hospital?

Joanna Pahl: Please give us a moment.

Kadie Derby: It needs to be prior to the patient's admission to the IRF. It cannot be after.

Joan Ranza: Okay. So, as long as the physical signature is there before the patient arrives, we could still override as long as he is physically doing it prior to admission?

Kadie Derby: Correct.

Joan Ranza: Thank you.

Operator: Your next question comes from the line of Shawn McMillis.

Shawn McMillis: Hi. Good afternoon. My question relates to the student issue again only because this topic has come up in question quite often during this call. However, this topic was not listed on this presentation at all.

So, we're really only addressing this via questions. But my question concerns the conditions of participation. Is this a recent change to the conditions of participation or is this – or has this been around for as long as the CoPs have been around?

Susanne Seagrave: So, to answer your question, I believe that this particular provision that I've been referring to, I think, it's 482.56, I believe. I think that that provision was revised in 2014, is my memory of it. So, it has been around since at least then. I'm not 100 percent sure what it said prior to then, but it's been around since at least 2014.

Joanna Pahl: Thank you.

Operator: Your next question comes from the line of Martha Ramirez.

Martha Ramirez: Hi. Good afternoon. My name is Martha Ramirez and I'm from the Del Sol Patient Rehab. And I just have a question regarding the new CMGs.

With the elimination of the FIM scores and the use of a new standard assessment for the CMGs, what's going to happen with comorbid condition that few are comorbid conditions? Is that something that is going to be considered for the new CMGs?

Catie Kraemer: Hi. This is Catie. There won't be any changes to the list of comorbid conditions that are currently used.

Martha Ramirez: Thank you.

Joanna Pahl: Thank you.

Operator: Your next question comes from the line of Jennifer Weiss.

Jennifer Weiss: Hi. This question was asked in a certain way before, but I just want to clarify. If the physician, for some reason, was unable to sign the pre-admission screen before the patient was admitted, it was completed and signed by the licensed clinician who did the screen. What would happen to that? Would that entire claim be denied?

Susanne Seagrave: It's certainly subject for denial because that does not meet our requirements. It is not - the signature of the clinician completing the pre-admission screening. It is the signature of the rehabilitation physician.

Joanna Pahl: Thank you.

Operator: Your next question comes from the line of Sheryl Lee.

Krishna Gada: Hi. Good afternoon. This is Krishna Gada from University of Maryland Rehab and Ortho. We are a rehab hospital but also part of a university system of hospital – 16 hospitals.

And my question is that suppose one of the other hospitals, rehabilitation doctor who was on the university payroll sees a patient, does a consult, and the consult has all the requirements of the pre-admission screen fulfills all the requirements, and signs the consult.

Does the rehabilitation doctor again has to sign the note which has been done previously by another doctor who was not on the payroll of the rehab hospital but is in the payroll of the university?

Kadie Derby: Can you actually go ahead and just send that to our e-mail box, the IRF coverage e-mail box that we have mentioned several times?

Susanne Seagrave: It sounds like a very specific issue.

Krishna Gada: Okay.

Joanna Pahl: Thank you.

Operator: Your next question comes from the line of Katie Miller.

She has withdrawn her question.

Your next question comes from the line of Michelle Doria.

Michelle Doria: Hi, Yes, we're calling from Lafayette General Medical Center and Patient Rehab Unit. With regard to the question that has evidently perplexed a lot of people about student involvement, does that imply that student physicians or medical students who are rounding with the physiatrist are also excluded from participating and documentation on the IRF?

Susanne Seagrave: So, this is Suzanne the answer to your question really depends. There are certain things that we require only the rehabilitation physician to document and we've sort of reference those in our slide

presentation but if there are other things besides those specific things that must be documented by a rehabilitation physician there are other things that students can absolutely document, one I mean physician students, I mean residents.

So, what we have been discussing up until now are the rules regarding therapy students. Physician students are an entirely different category.

Michelle Doria: Okay, let's just say for example there are three visits that are required per 7-day period those can be conducted by the resident student physician and co-signed by the physiatrist.

Susanne Seagrave: I think that those are one of the things that we require to be documented by a rehabilitation physician however the resident can see the patient other times and have that be, in addition to the minimum three physician visits a resident can visit the patient on other occasions and document that per the normal physician supervision rules.

Joanna Pahl: Thank you

Michelle Doria: Okay. Thank you

Operator: Your next question comes from the line of Rob Cantor

Rob Cantor: Hi this is Rob Cantor with the Advocate Healthcare. Recently, the IRF issue has been approved for RAC audit across the nation. What kind of education have you provided to the auditors and the contractors to make sure that they understand all of these rules that they will be reviewing for?

Susanne Seagrave: Hi. That question is a little bit outside the scope of this presentation. We don't have any CMS people from the RAC area here today, so we cannot answer that question. If you want to just go ahead and send it to the IRF coverage mailbox we will forward it to the appropriate people. Thank you.

Joanna Pahl: Thank you.

Operator: Your next question comes from the line of Renee Thorsbold

Renee Thorsbold: This is Renee Thorsbold from the Ohio State University Wexner Medical Center. My question relates to slide 23, at Ohio State we have a large and growing non-traumatic rehab population with impairments due to cancer. These patients are often poorly defined within the current IGC list.
Many patients could fit into 2 or 3 different IGCs. Does the post-admission physician evaluation need to specifically address agreements with the pre-admission predicted IGC when reviewing a patient's prior and current medical and functional condition?

Susanne Seagrave: I think that's a really specific question and I think that it would be better addressed if you sent that to our IRF email box.

Renee Thorsbold: Okay thank you.

Susanne Seagrave: Sure

Operator: Your next question comes from the line of Serene Davis. Ms. Davis Your line is open. There is no response from that line. Your next question comes from the line of Joan Ranza.

Joan Ranza: Thank you. Quick question, how would the cognitive issues be addressed both admission and discharge with the new system with doing away with the FIMs and going with functional?

Joanna Pahl: Please give us one moment.

Catie Kraemer: I can refer you to the technical report that was published with the fiscal year 2019 our PPS final rule for more information on how those items would be incorporated in our analysis. Thank you.

Joan Ranza: Thank you.

Operator: Your next question comes from the line of Janet Blake.

Janet Blake: Yes, Hi. My question is regarding the physician. The PMNR involvement with the physician visits. The three visits per week it's the resident actually enters a note with the PMNR with the resident and attest that he was with the patient and agrees with what was written.

Would that, would that be one of the physician requirements for the three visits? If they actually attest that they were with them and agreed with what the resident entered.

Susanne Seagrave: Hi. This is Susanne. Our requirements are that a rehabilitation physician a rehabilitation physician, a licensed physician with specialized training and experience in Medical Rehabilitation visit the patient face to face at least three times per week and document those visits.

Beyond that if you're kind of getting into the weeds of a specific situation that you might want to send that to the IRF coverage mailbox, so we can answer it more directly. Thank you

Janet: Okay thank you.

Operator: As a reminder, if you would like to ask a question please press star then the number one on your telephone keypad. That is star one to ask a question.

One moment for your next question.

Please hold for your next question.

Your next question comes from the line of Mary Hubert.

Mary Hubert: Hi this is Mary Hubert from the Ohio State University Wexner Medical Center. My question is in regards to the student-the therapy students, can you tell us where that provision was listed? We're not finding it.

Susanne Seagrave: Hi this is Susanne again so it's in 42 Code of Federal Regulations and I mean you can Google this. I think it comes up pretty easily on Google -- 42 Code of Federal Regulations 482.56 And it is- What subsection is that?

Kadie Derby: We don't have that information.

Susanne Seagrave: I don't have the subsection right away but just a short, it's a short subsection in 482.56 and it's towards the bottom where it says that it gives the different types of therapists and therapy assistants that may be involved in providing rehabilitation services in a hospital setting and it also says that Part 484 which is also in 42 it's a different part of 42 Code of Federal Regulations. Part 484 lays out the specific qualifications that those therapy disciplines must meet. Thank you

Mary Hubert: Thank you.

Operator: Your next question comes from the line of Mary Strait. Mary Strait your line is open.

Mary Strait: Hi. This is Mary Strait from Inova. One more question with related to the students. Somebody did ask if the students can write the note in the medical record and have the licensed clinician co-sign it. Is that acceptable?

Susanne Seagrave: So, can you clarify? So, you're talking about physician students, right?

Mary Strait: Therapist.

Susanne Seagrave: Therapy students? We say that they cannot perform the services. That it must be a licensed therapist or therapy assistant performing the services.

Mary Strait: But can the students write the note and the licensed clinician co-sign the note in the medical record?

Susanne Seagrave: That's a really get granular question can you send it to the IRF coverage mailbox and we'll respond.

Mary Strait: Okay thank you

Joanna Pahl: Thank you.

Operator: Your next question comes from the line of Anne Huff.

Anne Huff: Hi this is Anne Huff and I was calling to ask if you would be able to publish the answers to the questions that you have referred to the IRF coverage mailbox during this broadcast so that we can have that in the notes?

Catie Kraemer: No actually if you do have additional questions that you need a direct answer to please submit them yourself to the IRF coverage mailbox.

Joanna Pahl: Thank you.

Operator: Your next question comes from the line of Jan Time. Ms. Time your line is open. There's no response from that line. Your next question comes from the line of inaudible hospital.

Unidentified Female: Will you please clarify what role the therapy student would have in an inpatient rehab setting?

Susanne Seagrave: According to the hospital conditions of participation that IRF must meet, they don't have a role for students for therapy students in the inpatient rehabilitation facility setting.

Joanna Pahl: Thank you.

Operator: Your next question comes from the line of Janet Hubbold.

Janet Hubbold: Hi this is Janet from Burke Rehab thank you for taking my call. Quick question regarding the residents, so can a PMNR resident complete the H&P and post-admission assessment if the licensed rehab physician attest to participating and co-signs that note.

Kadie Derby: They can certainly complete the H&P but the post-admission physician evaluation should be completed by the rehabilitation physician.

Joanna Pahl: Thank you

Operator: Your next question comes from the line of Amy Wilburn.

Amy Wilburn: Yes, I'm Sorry I have a question about the student therapist again. If the PTA is giving the treatment and the students participating with the PTA, the PTA writes it or the student writes the note in the PTA or helped write the note and the PTA cosigns with it but the PTA is directing the therapy is that compliant or not.

Susanne Seagrave: Again, that's a really specific scenario can you please send that to the IRF coverage mailbox?

Amy Wilburn: Sure. Thank you.

Operator: Your next question comes from the line of David Costello.
David Costello: This relates to the student issue as well clearly there's a lot of disconnect between everyone on the call's utilization of students within the inpatient rehab location and what the interpretation that you're presenting now.

Within that 42.56 it also speaks to the national standard practice of the APTA and the AOTA and both of those speak to the utilization of student one is to either ask for you to revalidate the utilization of students in the IPR setting for clarification purposes or come up with a better understanding as to how they can be utilized in that setting because it's happening across the country.

Susanne Seagrave: This is Susanne thank you for that comment we'll take it under consideration.

Joanna Pahl: Thank you.

Operator: Your next question comes from the line of Rebecca Brewin.

Rebecca Brewin: Hi this is Rebecca from Spalding Cape Cod I was calling early I think somebody asked if there was any chance, we could get the answers to a lot of these questions since we're all on the call together and listening and several of them are going to an e-mail. It would be helpful to know those answers.

Catie Kraemer: We can take that into consideration.

Todd Smith: Thank you.

Operator: Your next question comes from the line of Jan Fader.

Jan Fader: Hi, I had a question, clarification regarding the certifying consults that was always a method to be able to admit patients through the use of a certifying consult from a PMNR physician. Is that still a method?

Kadie Derby: I'm not sure I actually understand your question. Can you clarify it? What is certifying consults? We don't know what that means.

Jan Fader: So, we're working in an IRF and we have a physiatrist who refers patients to us who is in another health system not even our own and that physician does an entire evaluation of a patient.

A physiatrist who does an evaluation of a patient we've been able to utilize that previously in lieu of a pre-admission assessment because it's a physiatrist who completed that and that was always you know in lieu of a pre-admission assessment. Is that…

Kadie Derby: No, that wouldn't meet our requirements. The pre-admission screening needs to be completed by an employee of the IRF not a referring hospital that could be a very big conflict of interest.

Jan Fader: Okay

Joanna Pahl: Thank you

Operator: Your next question comes from the line of Anne Clark

Anne Clark: Hi, it's Anne Clark I just was another question on the student programming we're having a hard time finding your conditions of participation 484 because the other one you gave us just speaks to the orders of a physician and their scope of practice it does not address the utilization of students so it's 482.56 just speaks to a physician so can you give further clarification on 484?

Joanna Pahl: Could you give us one second please.

Susanne Seagrave: Hi this is Suzanne we've been conferring on how best to direct you to part 484. I think the best course of action if you send your question to the IRF coverage mailbox we can email you both the provision at 482.56 and the provisions at 484 we can email you those sections so that you can read them. Thank you.

Anne Clark: Okay. Thank you I have the first one but the 484 would be great. We'll email you.

Operator: Your next question comes from the line of Janet Blake.

Janet Blake: Yes, my question is regarding Slide 19 about the IRF. If you're dealing with a pediatric population in the IRF does the PRI need to be completed even if it's not a Medicare patient?

Kadie Derby: All of the coverage acquirements that we were discussing today the documentation requirements as well as the coverage criteria that we covered in today's call all apply if you are billing Medicare Part A Fee-for-Service for a patient's care they do not apply if you're not billing Medicare Part A Fee-for-Service for that patient's care. Thank you.

Joanna Pahl: Thank you

Operator: Your next question comes from the line of Sharrine Davis

Sharrine Davis: Our question has been answered. Thank you.

Operator: Your next question comes from the line of Julie Price.

Julie Price: Hi this is Julie Price can you clarify on Slide 26 the note about the brief exceptions policy not allowed to be in the first three days.

Is that current for fiscal year 2019 first, and if so, does that mean that if we have a patient, we're sending out the process would be to discharge them rather than put them on the bed hold if it's within the first three days of their IRF stay?

Susanne Seagrave: Hi this is Susanne. So, first of all that requirement that the brief exceptions policy not be applied within the first three days is because again, that has been in place since we put these coverage requirements in place in January 1st, 2010.

That has always applied since January 1st, 2010 and the reason for it is because we do not want patients transferred before they are able — transferred from the referring hospital or from another setting until they are able to fully participate and benefit from the intensive rehabilitation therapy provided in the IRF.

So that is the reason for it because we don't allow patients to just sort of linger in the IRF for the first few days of their admission so if they're not able to fully benefit from it and participate in the rehabilitation therapy then they should not be transferred to the IRF yet and then once they are transferred we do not expect an unexpected clinical event to occur immediately as soon as they're transferred.

If it does and if that unexpected clinical event like really means that they're no longer appropriate for that IRF treatment, then they need to be discharged to a more appropriate setting as quickly as possible.

However, if they're able to get past that unexpected clinical event and still benefit from the IRF care, then they can remain in the IRF. In the IRF setting. So, I hope that helps answer your question

Julie Price: To clarify real quick, so you're saying if a medical event comes up, they have to be put on the bed hold in the first three days, that's okay. This is more directed towards if they're not able to participate in the first three days. Is that correct?

Susanne Seagrave: Well we wouldn't expect an unexpected clinical event to occur immediately as soon as they're transferred to the IRF that would be — that would be very unusual

Julie Price: But what should we do if it does happen? Just discharge them or are we able to put them on the bed hold? I mean I understand it's not expected but we all know that things that are unexpected still sometimes happen.

Susanne Seagrave: That sounds like a really, really rare and specific case can you please send that to the IRF coverage mailbox and we'll get back to you.

Julie Price: Sure.

Joanna Pahl: Thank you. Dorothy, we have time for one final question.

Operator: Your final question comes from the line of Kara Gainer.

Kara Gainer: Hi thank you this is Kara Gainer from the American Physical Therapy Association and I and AOTA and ASHA have been listening to today's call and on behalf of the three organizations APTA, AOTA and ASHA I just wanted to let those on the phone know that the three professional societies have requested a meeting with CMS to discuss the hospital conditions of participation and the use of therapy students in hospitals including IRF and so hopefully more information will be forthcoming. Thank you.

Additional Information

Joanna Pahl: Unfortunately, that is all the time we have for questions today. If we did not get to your question you can email it to the address listed on Slide 42.

We hope you will take a few moments to evaluate your experience. See slide 43 for more information an audio recording and transcript will be available in about 2 weeks at go.cms.gov/npc.

Again, my name is Joanna Pahl. I would like to thank our presenters and also thank you for participating in today's Medicare Learning Network event on IRF Prospective Payment Systems. Have a great day everyone.

Operator: Thank you for participating in today's conference call you may now disconnect. Presenters please hold.