Inpatient Rehabilitation Facility (IRF) Review Choice Demonstration (RCD) Review Guidelines

Background

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.

I. Medical Necessity: 42 CFR §§412.622(a)(3), (4), and (5)

The documentation in the patient's IRF medical record must demonstrate a reasonable expectation that the criteria for medical necessity were met at the time of admission to the IRF under 1862(a)(1)(A)(i) of the Social Security Act if the patient meets all of the following requirements:

- Active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy), one of which must be physical or occupational therapy.
- Generally, requires and can reasonably be expected to actively participate in, and benefit from, an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy) per day at least 5 days per week, or at least 15 hours per week[1] However, this is not the only way that such intensity of services can be demonstrated. The reviewer shall use clinical review judgment to determine medical necessity of the intensive rehabilitation therapy program based on the individual facts and circumstances of the case, and not on the basis of any threshold of therapy time.
    - *Note: 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. The Brief Exceptions Policy is for unexpected clinical events occurring 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.). If these reasons are appropriately documented in the patient's IRF medical record, such a break in service (of limited duration) should generally not affect the determination of the medical necessity of the IRF admission.*
- Patients must be able to actively participate in and benefit from the intensive rehabilitation therapy program prior to transfer from the referring hospital at the time of admission to the IRF.

[1] A "week" is defined as a 7 consecutive calendar day period, starting with the date of admission.

- Benefit from this intensive rehabilitation therapy program is demonstrated by measurable improvement that will be of practical value to the patient in improving the patient's functional capacity or adaptation to impairments.
- Required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF.
- Requires physician supervision by a rehabilitation physician, defined as a licensed physician determined by the IRF to have 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 (beginning with the first week) 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.
    - *Note: Beginning with the second week of admission to the IRF, a non-physician practitioner may conduct 1 of the 3 required face-to-face visits per week.*

II. IRF Documentation

To document that each patient for whom the IRF seeks payment is reasonably expected to meet the medical necessity requirements listed above at the time of admission, the patient's medical record at the IRF must contain the following documentation criteria:

A. Documentation requirements for all choice selections (pre-claim review, postpayment review, selective postpayment review, and spot check)

1) **Preadmission Screening:** 42 CFR § 412.622(a)(4)(i)

A comprehensive screening that serves as the basis for the initial determination of whether or not the patient meets the requirements for an IRF admission to be considered reasonable and necessary.

- Is there documentation of a preadmission screening (or evaluation of the patient's condition and need for rehabilitation therapy and medical treatment)?
- Was the PAS conducted by a licensed or certified clinician(s) designated by a rehabilitation physician within the 48 hours immediately preceding the IRF Admission?
- Required Elements-
    - 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,
    - Expected length of time necessary to achieve that level of improvement (i.e., estimated length of stay),
    - Evaluation of the patient's risk for clinical complications,
    - Conditions/comorbidities that caused the need for rehabilitation,
    - Treatments needed (i.e., physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), and
    - Anticipated discharge destination.

- The rehabilitation physician must also review and document concurrence with the pre-admission screening before the patient is admitted to the IRF.

Note: If the patient is being transferred from a referring hospital, the preadmission screening could either 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 should generally include 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 member in the IRF to ensure it includes a detailed and comprehensive review of the patient's condition and medical history in accordance with 42 CFR § 412.622(a)(4)(i)(B).

2) Therapy Evaluations/Skilled Notes

- Initial Physical Therapy Evaluation required
- Initial Occupational Therapy Evaluation required
- Initial Speech Language Pathology Evaluation required (if applicable)
- Physical Therapy Note(s) as available)
- Occupational Therapy Note(s) as available
- Speech Language Pathology Note(s) as available (if applicable)

3) Additional Supporting Documentation for Admission to the IRF

The documentation submitted **MAY** include a History and Physical, Plan of Care, Skilled Notes, Interdisciplinary Team note(s), Admission Orders, etc.:

- The beneficiary's need for intensive therapy, expected treatments/therapies, ability to participate in extensive therapy, etc. (History and Physical, Plan of Care, Skilled Notes, Interdisciplinary Team notes, etc.).
- At time of admission, the patient's condition required at least 2 therapy disciplines (one of which must be physical or occupational therapy) and that those services were initiated within 36 hours from midnight of the day of admit to the IRF.
- The rehabilitation physician has conducted the initial face-to-face visit(s) that are required to be conducted at least 3 days per week throughout the patient's stay in the IRF. (Beginning with the second week, a non-physician practitioner who is determined by the IRF to have specialized training my conduct 1 or 3 of the required visits).
- The rehabilitation physician is a licensed physician who has been determined by the IRF to have specialized training and experience in inpatient rehabilitation.

B. The following documentation is required to be submitted with Choice selections 2, 3, and 4 (postpayment review, selective postpayment review, and spot check). Some of these documents may be submitted for resubmissions of pre-claim review request if needed to determine medical necessity.

1) **Overall Plan of Care:** 42 CFR § 412.622(a)(4)(ii) (This documentation may not be available for submission of pre-claim reviews.)

The overall plan of care should generally detail the patient's medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRF stay.

- The rehab physician is responsible for developing the overall plan of care with input from the interdisciplinary team.
- The overall plan of care must be completed within the first 4 days of the IRF admission.
- It should generally include:
    - The expected intensity (meaning number of hours per day),
    - Frequency (meaning number of days per week),
    - Duration (meaning the total number of days during the IRF stay) of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies required by the patient during the IRF stay.

2) **Required Admission Orders:** 42 CFR § 482.12(c)(2), § 482.24(c), and § 412.3

A physician must generate admission orders for the patient's care. These admission orders should generally be retained in the patient's medical record at the IRF.

- The inpatient rehabilitation admission order is a condition of participation, and not something review contractors assess on a claim-by-claim basis to determine appropriateness of payment.
- Medical reviewers shouldn't review for, or deny, based on the lack of an admission order.

Note: In rare circumstances the order to admit is missing or defective, yet the intent, decision, and recommendation of the ordering physician or other qualified practitioner to admit the beneficiary as an inpatient can clearly be derived from the medical record. An example, a signed pre-admission screening can satisfy this admission order requirement*. Medical review contractors have the discretion to determine that this information constructively satisfies the requirement that a written hospital inpatient admission order be present in the medical record per* § 482.24(c).

3) **Interdisciplinary team approach to care:** 42 CFR 412.622(a)(5)

The information in the patient's IRF medical record must document a reasonable expectation that the patient required an interdisciplinary team approach to care. The documentation supports the following:

- Interdisciplinary approach—interdisciplinary team meetings held a **minimum of once per week**
- **Must include the following persons**: a rehabilitation physician; registered nurse; social worker or a case manager (or both); and licensed or certified therapist from each therapy discipline involved in treating the patient.
- Must be **led by a rehabilitation physician** either in person or remotely **who documents concurrence** with all decisions made at each meeting.
- **Interdisciplinary team meeting to 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.

4) **Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI):** 42 CFR § 412.604(c)

As per the requirements, the IRF patient assessment instrument (IRF-PAI) forms should generally be included in the patient's medical record at the IRF (either in electronic or paper format).