

See the Post Call Clarification document for updates to this transcript

**Centers for Medicare & Medicaid Services
Inpatient Rehabilitation Facility
Prospective Payment System Coverage Requirements
National Provider Call
Moderator: Leah Nguyen
May 31, 2012
2:00 p.m. ET**

Contents

Introduction.....	2
Presentation.....	3
Polling.....	7
Presentation (Continued)	8
Question and Answer Session.....	12
Additional Information	39

Operator: At this time, I would like to welcome everyone to the Inpatient Rehabilitation Facility Prospective Payment System Coverage Requirements National Provider Call.

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. Thank you for your participation in today's call.

I will now turn the call over to Leah Nguyen. Thank you, ma'am. You may begin.

Introduction

Leah Nguyen: Thank you, Holley. Hello. I am Leah Nguyen from the Provider Communications Group here at CMS, and I'll serve as your moderator for today's call.

I would like to welcome you to the Inpatient Rehabilitation Facility Prospective Payment System Coverage Requirements National Provider Call.

Beginning on January 1st, 2010, all Medicare fee-for-service inpatient rehabilitation facility claims were required to meet new coverage requirements for payment under the IRF Prospective Payment System.

During this National Provider Call, CMS subject matter experts will provide an overview of the requirements and address questions and – that providers continue to have as they apply these requirements.

Before we get started, there are a few items that I need to cover. The link to the slide presentation for today's call was e-mailed to all registrants earlier this afternoon. The presentation can also be downloaded from the CMS Fee-For-Service National Provider Calls Web page at www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the Web page, select National Provider Calls and Events. Then select the May 31 call from the list.

This call is being recorded and transcribed. An audio recording and written transcript will be posted soon to the National Provider Calls and Events section of the CMS Fee-For-Service National Provider Calls Web page.

At this time, I would like to introduce our CMS subject matter experts for today. We are pleased to have with us Gwendolyn Johnson and Susanne Seagrave from the Division of Institutional Post-Acute Care.

And now, it is my pleasure to turn the call over to Gwendolyn Johnson, who will begin our presentation.

Presentation

Gwendolyn Johnson: Thank you, Leah. This is Gwen, and I'll go ahead and start our presentation off today with the slides. We can start with slide number two.

Today, we'd like to give an overview of the – of Medicare's IRF coverage policies as well as answering questions you have about these policies.

The IRF benefit is designed to provide intensive rehabilitation therapy in a resource-intensive hospital environment. Additionally, 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 approach to the delivery of rehabilitation care.

Patients must be able to fully participate in and benefit from an intensive rehabilitation therapy program prior to transfer from a referring hospital. As well, patients should – patients who are still completing their course of treatment in the referring hospital and cannot tolerate an intensive therapy program are not appropriate for IRF admission.

Other patients that may not be appropriate for IRF admission would be patients who have completed their course of treatment in the referring hospital but do not require or cannot participate in or benefit from an intensive rehab therapy program.

On slide six, there is a list of documentation requirements for the IRF PPS. I won't go down each one individually. You can take a look at those right now. Moving on, to slide eight, we'll go – begin our discussion of the pre-admission screening. The preadmission screening is a comprehensive – the comprehensive pre-admission screening process is the key factor, we believe, in initially identifying appropriate candidates for IRF care.

The preadmission screening should be conducted by a licensed or certified clinician, conducted in a person – in person or through a review of the patient's referring hospital medical records. It should also include a detailed and comprehensive review of the patient's condition and medical history.

We continue to talk about preadmission screening and, on slide 10, regarding personnel. A licensed or certified clinician is an individual who is appropriately trained and qualified to assess the patient's medical and functional status. They should be able to assess the risk for clinical and rehabilitation complications, as well as have the ability to assess other aspects of the patient's condition, both medically and functionally.

Moving on to slide 11, listed on this slide is key information which, we believe, is paramount for the foundation of a good pre-admission screening. Again, on – in hopes of moving through our slides so that we get to spend most of our time being available to you for questions, I will not go down each one of the listed items, but have you take a look at those in your time.

On slide 12, we continue with the pre-admission screening. Pre-admission screening must be conducted within the first 48 hours immediately preceding the IRF admission or, alternatively, it must contain documentation of an update within the 48-hour time period if a – of a – if a comprehensive screening containing all the required elements was conducted more than 48 hours prior to the admission.

I think I might want to say that again. It 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 admission. It must be signed, dated, and timed by a rehabilitation physician.

A rehabilitation physician's concurrence – and it must be documented – the rehabilitation physician's documentation should – their concurrence should be documented with the findings and results of the pre-admission screening after the pre-admission screening is completed and before the IRF admission.

The pre-admission screening should support the admission decision and serve as the initial determination of whether or not the patient meets the requirements for an admission – IRF admission to be considered reasonable and necessary. It should be used to inform the rehab physician about the patient and should be retained in the patient's medical record at the IRF.

The pre-admission screening serves as the primary documentation by which the IRF clinical staff indicates the patient's status prior to admission and the specific reasons that led the IRF clinical staff to conclude that the IRF admission would be reasonable and necessary.

The pre-admission screening must contain some narrative information. It should not be in the form of check-off boxes, as check-off boxes do not adequately demonstrate that an individualized assessment took place. A detailed description must document the condition or comorbidities the patient has and why these indicate a specific risk for clinical complications that require physician monitoring. Clinicians conducting the pre-admission screening must write out the detailed reasoning or justification for the IRF admission.

Moving on to slide 17, where we discuss – we will begin our discussion of key elements of post – of the post-admission physician evaluation. First, let's begin at slide 18 regarding the purpose of the post-admission physician evaluation.

This is to check whether the patient's status on admission still reflects what's in the pre-admission screening – what was in the pre-admission screening – or document any changes that may have occurred.

The purpose – also, the purpose, as well, is to ensure that a rehabilitation physician sees the patient in the first 24 hours of admission and begins the development of the patient's expected course of treatment as soon as possible.

Required information for the post-admission physician evaluation includes documentation of any relevant changes that may have occurred since the pre-admission screening and include a documented history and physical exam and should also include documentation that supports the medical necessity of the admission. The post-admission physician evaluation should also review the patient's prior and current medical and functional conditions and comorbidities.

On slide 20, we will then begin our discussion of the key elements of the individual's – individualized overall plan of care. An overall plan of care must be individualized to the unique care needs of the patient and is based on information from the pre-admission screening and post-admission physician evaluation. This information is garnered from therapy assessments. An important element of the overall plan of care is that it must be synthesized by the rehab physician and must be completed within four days of the IRF admission.

Required documentation or required information for the overall plan and care are listed on slide 22 – estimated length of stay, medical prognosis, any anticipated interventions, functional outcomes and a discharge destination as well as expected therapy.

Additional information regarding the overall plan of care – and though it may be a good practice, the first team meeting does not have to occur in the first four days to establish the overall plan of care. And, also, importantly, the overall plan of care is the rehabilitation physician's responsibility.

Next, we go to admission orders requirements and we'll move on to slide 25. At the time of admission, a physician must generate admission orders for the patient's care that must be retained in the patient's medical record at the IRF.

The IRF-PAI requirements – moving on to slide 27, requirements for the IRF-PAI. The IRF-PAI must be contained in the patient's medical record at the IRF. The information in the IRF-PAI must correspond and be consistent with all of the information provided in the patient's medical record.

Leah Nguyen: Thank you, Gwen.

At this time, we will pause for just a few minutes to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note there may be moments of silence while we tabulate the results.

Holley, we're ready to start polling.

Polling

Operator: CMS greatly appreciates that many of you minimize the government's teleconference expense by listening to these calls together in your office using only one line. Today, we would like to obtain an estimate of the number of participants in attendance to better document how many members of the provider community are receiving this valuable information.

At this time, please use your telephone keypad and enter the number participants that are currently listening in. If you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine.

Once again, if you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine.

Please hold while we complete the polling.

Please continue to hold while we complete the polling.

Thank you for your participation. And I will turn the call back over to Leah.

Leah Nguyen: Thank you, Holley.

At this time, I would like to turn the call over to Susanne Seagrave, who will continue the presentation.

Presentation (Continued)

Susanne Seagrave: Thank you, Leah.

I am going to walk through the five IRF coverage criteria that are listed on slide 28.

On slide 29, the first coverage criteria for an IRF claim to be reasonable and necessary is that the patient must require multiple therapy disciplines. Patients who only require one therapy discipline of treatment do not need to be in an IRF. For this purpose, the therapy disciplines include physical therapy, occupational therapy, speech-language pathology, and orthotics/prosthetics.

On slide 30, an additional requirement is that one of the therapy disciplines must be either physical or occupational therapy, though I note that most patients in an IRF will need both.

On slide 31, I'm going to talk about the intensive rehabilitation therapy requirement, which is one of the real core requirements. Patients must require an intensive rehabilitation therapy program on admission to the IRF. That's not to say that they can require it several days after admission. They need to require this intensive therapy program on admission.

This is not used as a rule of thumb. But it is typically demonstrated in IRF by the provision of therapies, at least three hours per day, at least five days per week. That's the industry standard that has been used for many years.

Alternatively, for certain patients who benefit from an alternative schedule of care, an average of at least 15 hours per week can be provided. I note though it's not on the slide, that, additionally, we will consider other ways of demonstrating this if IRF comes forward with other ways.

On slide 32, a very important point that we get asked questions on all the time – is what is our definition of a week for this – the provision of the therapy. A week is a seven-consecutive-day period starting with the day of admission. So, for example, if a patient is admitted on a Tuesday, they must receive the intensive rehabilitation therapy program for the week by the following Monday, i.e., seven consecutive calendar days later.

On slide 33, I'm going to discuss the initiation of therapy. Required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF. This means, for example, if a patient is admitted on Thursday, May 31, any time before midnight, then the patient's therapy treatment must begin no later than noon on Saturday. So, that is 36 hours from midnight on Thursday.

Therapy evaluations may constitute the initiation of therapy services. And therapy evaluations do count for the purposes of demonstrating the intensity of therapy requirement.

On slide 34, I'm going to talk about group therapy as applied to the intensive rehabilitation therapy requirement. The standard of care for IRF patients is individualized, i.e., one-on-one therapy, one therapist with one patient. Group therapies may serve as an adjunct to individual therapies for certain patients for which this treatment modality may be appropriate. Justification for the use of group therapies in a particular case should be documented in the patient's medical records at the IRF, i.e., the reasons why this is an appropriate treatment modality for the patient.

On slide 35, I'm going to briefly discuss the brief exceptions policy to the intensive rehabilitation therapy requirement. Contractors are authorized to grant brief exceptions not to exceed three consecutive calendar days to the intensity of therapy requirement for unexpected clinical events. And, on slide 35, you can see a brief, though not all-inclusive list of some of the examples of what could constitute an unexpected clinical event.

Continuing on slide 36, the reasons for the brief interruption in the intensive therapy program must be well-documented in the patient's medical record at the IRF, i.e., an explanation of what the unexpected clinical event was and how it affected the patient's intensive rehabilitation therapy program.

On slide 37, I'll move to the third criteria for a patient's admission to an IRF to be reasonable and necessary. 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. So, that's key. The patient must be able to participate in this program when they enter the IRF.

On slide 38, I'll talk about another very critical criterion for an IRF claim to be reasonable and necessary. It must be demonstrated that the patient requires face-to-face visits by a rehabilitation physician or other licensed treating physician with specialized training and experience in rehabilitation at least three days per week throughout the IRF stay.

On slide 39, some additional discussion of the required physician visits. Again, they must be performed by a rehabilitation physician. They must be a comprehensive assessment of patients' functional goals and progress in light of their medical conditions. So, it's not just a blood pressure check and continue therapy. It must be a comprehensive assessment of the patient.

And rehabilitation physicians or other physician specialties may treat and visit the patient more often as needed. This is just a minimum requirement, not – certainly not a maximum requirement.

On slide 40, the final criterion is that the complexity of the patient's nursing, medical management, and rehabilitation needs must require an inpatient stay and an interdisciplinary team approach to care. An interdisciplinary team approach to care is designed to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve the treatment goals.

As such, on page 42, we discuss the required team participants at the weekly team meeting. It must – the team meetings must be led by a rehabilitation physician. They must also be comprised of a registered nurse with specialized training or experience in rehabilitation, a social worker or case manager or both, and a licensed or certified therapist from each therapy discipline involved in treating the patient. And these participants must all be familiar with the patient's case.

On slide 43, we discuss what the interdisciplinary weekly team meetings must focus on. They must focus on assessing the individual's progress towards their goals, considering possible resolutions to any problems that could impede their progress, reassessing the validity of the rehab goals, and monitoring and revising the treatment plan as needed. So the participants in the meeting must all be appropriately licensed and qualified to be able to perform all of those functions.

On slide 44, I just briefly touched on – this is not one of the criteria for admission. But the general goal of IRF treatment should be the patient's safe return to the home or community-based environment. However, patients do not have to be expected to achieve complete independence in the domain of self-care nor do they have to be expected to be able to return to their prior level of function. They may or may not be able to return to their prior level of function, but that can – should not be an exclusion factor to their admission to an IRF.

On slide 45, I give some citations for where to find information on these policies. And there are links on that slide that you can go to.

I will now turn it over to Leah.

Leah Nguyen: Thank you, Susanne.

We have completed the presentation portion of this call. Before we begin the question and answer session, I would like to remind everyone that this call is being recorded and transcribed.

Before asking your question, please state your name and the name of your organization. In an effort to get through as many of your questions as possible, we ask that you limit your question to just one.

All right, Holley, you may open the lines for questions.

Question and Answer Session

Operator: Thank you.

To ask as a question, press star, followed by the number one, on your touchtone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking your question and pick up your handset before asking your question to assure clarity. Please note, your line will remain open during the time you are asking your question. So, anything you say or any background noise will be heard in the conference.

And your first question comes from the line of Pamela Glorie.

Pamela Glorie: Hi. Pamela Glorie from Memorial Health System, Colorado Springs, Colorado. My question is, it says here for required therapy treatments, they must be given within 36 hours from midnight on the day of admission to the IRF. But on our IRF-PAI the assessment period starts on the day that they are admitted. So we have that three-day period for assessment. How does that work if you don't have to see the patient per CMS guidelines until 36 hours from midnight?

Susanne Seagrave: No. I think it's the opposite. The latest possible time that you can begin therapy treatments on the patient is 36 hours from midnight on the day of admission. However, we would really encourage providers to start therapy treatments on the patient as soon as they get to the IRF as possible, although understanding that the first day that they arrive, they could be tired from the trip ...

Pamela Glorie: Yes.

Susanne Seagrave: ... or whatever. But we – but we are saying that 36 hours from midnight of admission is the absolute latest that they can start.

Pamela Glorie: The absolute latest, OK, so then on the IRF-PAI, you have that three-day where you take your (FEM) scores from – just get your first – so, if you were – say, you weren't able to start until 36, you'd still miss out on those three days.

Susanne Seagrave: Well, the therapy – the initiation of therapy is completely separate from filling out the IRF-PAI.

Pamela Glorie: Yes.

Susanne Seagrave: You need to fill out the IRF-PAI based on all of your assessments of the patient within that initial three-day window. It does – it doesn't depend on the latest start time that you can start therapy.

Pamela Glorie: Thank you.

Susanne Seagrave: OK.

Pamela Glorie: Thank you.

Operator: Your next question comes from the line of Heather Gibson.

(Mary): Hi. This is – actually, this is (Mary) with Heather, and we are with St. Louis Surgical Consultants. And the question is, is that we had two patients actually come into our office – and we’re surgeons – so they came in and saw the physician. And then, you know, we billed Medicare. Medicare has since come back – wanting their money back because they were IRF patients. Both of them were.

And my – our question is, how are we supposed to know that they were, you know, in IRF or not?

Susanne Seagrave: I don’t think that question is exactly within the scope of this call. You’re talking about patients who went to a physician’s office...

(Mary): Right.

Susanne Seagrave: ... when they were in the IRF?

(Mary): Yes. And Medicare came back saying that they were in an inpatient rehabilitation facility. But yes, they came to our office. We had no idea.

Susanne Seagrave: OK. That question is outside the scope of this call. But I can – I can try to ...

Jeanette Kranacs: Yes. Have you talked to your – to whoever – to your FI or MAC that denied the claim?

(Mary): Well, it was CMS HDI that came back stating they wanted the money back. And we were – when we called them, they said it’s because they were in the inpatient rehab facility.

Susanne Seagrave: Right. I mean, I’ve gotten questions on this type of thing before. But you need to – how do we – how do they contact me offline? Or ...

Leah Nguyen: What you can do is, if you could just e-mail the question to the resource box that we have set up on slide 47, we can look into it for you.

(Mary): OK. Thank you. Because we just didn't know – how are we supposed to know that these patients are in an IRF facility?

Leah Nguyen: OK. Thank you.

Operator: Your next question comes from the line of Diane Owens.

Diane Owens: We wondered – we want a clarification on required team participants. Is a licensed vocational nurse [LVN] acceptable to participate in the team conference?

Susanne Seagrave: Not as one of the – not as the registered nurse that is – that has specialized training and experience in rehabilitation. Others besides the required participants may attend. Certainly, anybody who has information to provide about the patient may attend. But the nursing participant in the team meeting must be a registered nurse.

Leah Nguyen: Thank you.

Operator: And your next question comes from the line of Yvonne Shell.

Yvonne Shell: My question is on the treatment goal. If the goal of the treatment is so that the patient can return safely back to their home environment, if we get an evaluation on the patient that, say, you know, on assessment, that this patient you will not be able to return to their home environment, but know that rehab treatment will help the patient functionally before they go to a skilled nursing facility, should the IRF anticipate admitting the patient?

Susanne Seagrave: Yes. If the patient meets all the criteria for admission – the reason that we put the word “generally” in the statement in the manual is that, generally, the goal of an IRF stay should be a patient's return to the home or community environment. However, if a patient meets the criteria for admission to an IRF and it is known that they will end up in a skilled nursing facility or another setting, that is still an acceptable admission to the IRF.

Yvonne Shell: Thank you.

Operator: Your next question comes from the line of Laneita Williamson.

Laneita Williamson: Hi. Yes, this is Laneita Williamson from Baptist Hospital in Winston-Salem, North Carolina. And the question I have is, on the post-admission physician evaluation – we're a research hospital – can they utilize fellows or midlevel providers such as nurse practitioners or anyone else to do that admission? Or, do they need to do the post-admission evaluation from head-to-toe by themselves?

Susanne Seagrave: The answer to your question is in two parts. We call them physician extenders, to our nurse practitioner, physician's assistant, and even medical – other types of physician extenders may do the history and physical exam for the physician.

However, the physician him- or herself is required to see the patient within the first 24 hours of admission and perform the other part of the post-admission physician evaluation, which would include, you know, evaluating the patient's current condition and functional status and comparing that with what is on the pre-admission screening. So, physician extenders can certainly perform the history and physical exam. But the rest of it is – has to be done by a rehabilitation physician.

Laneita Williamson: OK. Thank you.

Operator: Your next question comes from the line of Eric Wilcoxon.

Eric Wilcoxon: Hello, Eric Wilcoxon, University Health Systems, San Antonio, Texas. And my question is, what is legally sound and acceptable if the provider does that rewrite the pre-admission screening? An example is if they pulled a consult from the inpatient record, are they allowed to use that as the pre-admit screening? And if there are multiple providers, how do you tie it all together?

Susanne Seagrave: That is post – the answer to that is covered in our clarifications, which are posted on the coverage requirements Web page of the IRF PPS Web site. And, yes, we do say that a physician consult that contains all of the required information for the pre-admission screening can serve as the pre-admission screening. But again, it must include all the required information.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Linda Dean.

(Maryanne): Hello. This is (Maryanne), and I'm calling from Provena St. Joseph Hospital in Elgin, Illinois. My question is also on weekly team meetings and the documentation of those meetings. Do you prefer a specific form that we use?

Susanne Seagrave: Again, I keep forgetting to introduce myself. But this is Susanne who has been answering these questions.

And, no, we do not prescribe – for any of these requirements, we do not prescribe specific forms that must be used. We feel that the IRF facilities themselves need to determine what works best within their structure, however they have their medical records set up. But it needs to – all of these requirements, it needs to be clear to a medical reviewer that this documentation that they are looking at satisfies the interdisciplinary team meeting documentation requirement, for example. All of these requirements, it needs to be clear – clearly identified for a medical reviewer somehow.

(Maryanne): Next question, do you need a new form each week?

Susanne Seagrave: You need a new form each week?

(Maryanne): Or updating the one that's from the original team meeting?

Susanne Seagrave: That is – that's up to the individual inpatient rehab facility. But again, it must be clear to a medical reviewer who is looking at the record that you had a new team meeting on the patient weekly and what the discussions and

decisions that were made during that – during each team meeting are. If the medical reviewer cannot identify a new team meeting each week on the patient, then they – then, they may identify that the record is not adequately supporting the admission.

(Maryanne): My final question, when we do document the current function during that team meeting, does it need to be in a paragraph form? Or, can we use their (FEM) numbers?

Susanne Seagrave: We don't prescribe that level of detail on – you need to do what makes sense for describing the patient's goals and progress, however that makes most sense to the clinician to prescribe.

(Maryanne): Thank you.

Susanne Seagrave: Thank you.

Leah Nguyen: In an effort to get through as many of your questions as possible, we ask that you limit your question to just one. If you'd like to ask a follow-up question or have more than one question, you may press star one to get back into the queue and we'll address these additional questions as time permits.

Operator: Your next question comes from the line of Donna Patterson.

Donna Patterson: Hi. Donna Patterson from Carondelet Rehab in Tucson, Arizona. My question is in regards to post-admission assessment. We are down to only one podiatrist. And since he can't be here seven days a week, what he'd like to do is train other physicians to assist him with completing the post-admission assessments.

If a rehabilitation physicians trains a Med Surg physician on the appropriate documentation, and they have experience with covering the rehab unit, is that sufficient? Or, what is your definition of a rehab doctor, physician, completing that post-admission assessment?

Susanne Seagrave: A rehabilitation physician is defined as a licensed physician who is appropriately trained and qualified to treat and has experience in inpatient rehabilitation facility care. And it – the answer to your question is that, no, I don't believe what you're describing would be appropriate.

The regulations require the post-admission physician evaluation to be done by a rehabilitation physician. It does not have – I note – because I want to note this for everybody – that it does not have to be a podiatrist. It just has to be a rehabilitation physician as described in the regulations and in the manual.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Diane Glowicki.

Diane Glowicki: Yes. My name is Diane Glowicki. I'm from Munson Medical Center in Traverse City, Michigan. And my question is regarding the pre-admission documentation that is completed by a physician extender. Does that have to be signed by the physician prior to the patient's actual arrival on the rehab unit? Or, can the patient arrive and then that be signed?

Susanne Seagrave: Very good question. This is a key question in the documentation requirement. This is Susanne speaking again. It must – the physician – the documentation of the rehabilitation physician review in concurrence with the pre-admission screening which is authorizing the IRF admission must occur prior to the patient arrival at the IRF, i.e., we say that the patient is admitted to the IRF when they arrive physically at the IRF. So, that physician's documentation and his or her review in concurrence with the pre-admission screening must, must, must occur prior to the patient's IRF admission.

Diane Glowicki: Thank you.

Operator: Your next question comes from the line of Chris Provaznik. Chris, your line is open.

That question has been withdrawn. Your next question comes from the line of (Kyle Nedar).

(Kyle Nedar): Hello. This is (Kyle Nedar) from the Rehab Hospital of Indiana and Indianapolis. And my question is along the line of the pre-admission signatures and concurrence as well. We've had recent communication that an e-mail with a scanned pre-admission screen to the physician would count for the – for the signature in the concurrence. I just wanted to clarify that if – to make sure that that was acceptable, that an e-mail from the physician saying that she'd received the pre-admission screening, reviewed it and concurred, would that count?

Susanne Seagrave: We will need to get back to you on that question. Can you send that question to the IRF Coverage Resource mailbox that's on the second-to-last slide?

(Kyle Nedar): I sure can.

Susanne Seagrave: Thank you.

(Kyle Nedar): Thank you.

Operator: Your next question comes from the line of Linda DeYoung.

Cindy Sayce: Hi. This is Cindy from Moore Regional Hospital in Pinehurst, North Carolina. And our question is related to documenting participation in three hours of therapy. Must the therapy time be reported in minutes? Or, can the therapy time be reported in the 15-minute increment unit?

Susanne Seagrave: That is something that is up to the inpatient rehab facility to document. I know that different facilities document that therapy in different times – different blocks of time. So, that is really up to the rehabilitation facility to determine as long as they are clearly documenting that the patient required and received the appropriate amount of therapy.

Cindy Sayce: Thank you.

Operator: Your next question comes from the line of (Dawn Houston).

(Maria Conehouse): This is (Maria Conehouse). We are getting ready to go to an electronic medical record. And our question is, with the new process, the rehab doctor will be able to start the admission orders while the patient is still on the acute side of our facility. Is that going to be compliant with them doing the orders within the 24 hours after admission?

Susanne Seagrave: For the admission orders, the admission order just needs to be done in compliance with the conditions of participation which, honestly, I will have to get back to you on exactly what the timeframe for those admission orders are because I don't remember off the top of my head. Now, the post-admission physician evaluation part that must be done within the 24 hours of the patient's admission. That cannot be done before the patient arrives at the IRF.

(Maria Conehouse): OK. That does answer the question.

Susanne Seagrave: OK. Thank you.

Operator: Your next question comes from the line of Jill Biggane.

Jill Biggane: Hi. My question is about the team – the weekly team meeting – and the comment about the registered nurse. What do you feel the role – potential role of an LVN would be at a team meeting? And, as long as a registered nurse like a nurse supervisor is at the meeting, is that sufficient?

Susanne Seagrave: Well ...

Jill Biggane: In other words, are the LVNs – they're allowed to report off on what's going on with their patient, with the supervisor present?

Susanne Seagrave: Sure. Absolutely. That would be fine as long as the registered nurse was present and, yes, if the LVN has, you know, recent knowledge of the patient. They can certainly report on status.

Jill Biggane: OK. And we have then signed off on the team conference summary in addition to the nurse?

Susanne Seagrave: Again, that's fine as long as the nurse is also present and participating and signing.

Jill Biggane: OK. Thank you.

Operator: Your next question comes from the line of Marilyn Tiarks.

Marilyn Tiarks: Hi. Yes. I have a question regarding the pre-admission screening. Our physicians actually do a consult on the acute unit. Then they do a brief documentation on the acute chart then accepts that patient if they are appropriate. They then dictate a complete consult. Is it OK if the consult is actually dictated after the patient is on the rehab unit as long as they have written their note accepting them?

Susanne Seagrave: Well, the – all of the required information for the pre-admission screening must be documented, and then the rehabilitation physician's concurrence with the IRF admission must all be documented prior to the admission. They're certainly free to document additional information after the admission. But all of the required elements of the pre-admission screening, including the physician concurrence, must be documented prior to the admission.

Jeanette Kranacs: That's part of the person's IRF medical record. It can't be just done in the acute care medical record.

Marilyn Tiarks: No. They actually do it on that part of the chart. It's just that the consult they may dictate, if they say it's OK to come, we bring the patient immediately and they may dictate it an hour or so later.

Susanne Seagrave: Well, I mean, they need to be dictating everything that is a required element of the pre-admission screening prior to the admission. They're – they can document additional information after if they – if they wish.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Jenny Hertter.

Jenny Hertter: Yes. I was just wondering if it is acceptable just to list the members of the interdisciplinary team in their conference notes in – with the physician sign off – or if each team member has to sign off.

Jeanette Kranacs: Why don't – why don't we verify that via the mailbox and send it back to you just so that we're sure we give you the right answer.

Jenny Hertter: OK. Thank you.

Leah Nguyen: And, again, that's on slide 47.

Jenny Hertter: OK.

Susanne Seagrave: Yes. We'll just be verifying exactly what it says in the Medicare Benefits Policy Manual, section 110. I don't remember the exact language of what's required for the listing of the participants. If you want to check that as well, we'll check that and get back to you as well.

Jenny Hertter: OK. Thank you.

Operator: Your next question comes from the line of Beth Rudisill.

Elizabeth Rudisill: Hi. This is Elizabeth Rudisill from the WakeMed Rehab in Raleigh, North Carolina. And my question is around slide 34 and the standard for IRF care being individualized. And I wondered in you could speak to your thoughts on concurrent therapy. I know that there has not been a real clear definition of individualized versus group versus concurrent in this particular aspect of the industry. And I wondered if you had some thoughts to offer there.

Susanne Seagrave: We have not issued a definition for the IRF setting of group and concurrent therapy. Group – concurrent and group therapy would not be

considered individualized one-on-one therapy. To date, we have treated group and concurrent therapy essentially the same in our IRF policy. So I don't have a definition to give you. However, anything other than one therapist with one patient would be sort of the same policy as group policy in an IRF setting.

Elizabeth Rudisill: OK. Thank you.

Operator: Your next question comes from the line of Heather Baker.

Heather Baker: Hi. Good afternoon. I wanted to ask about slide 21 and the premise that the physician must synthesize the individualized plan of care. Could you speak to what the intent is behind that particular requirement?

Susanne Seagrave: Sure. Absolutely. Again, I keep forgetting to introduce myself. But this is Susanne. What we mean by that is that the overall plan of care is really the physician's responsibility. But we definitely hope/expect that the physician will certainly involve the other team members in the overall plan of care. We'll certainly talk to them about their experience with the patient, you know, particularly the therapist.

The physician may want to talk with them about, you know, what their impressions of the patient are. And it's the rehabilitation physician's responsibility to gather all that information from the team members and synthesize it into an overall plan of care. So, we mean just to, you know, to gather all the different perspectives from the different team members, the registered nurse, the therapist, the social worker, the case manager, et cetera – bring all that information together as needed and compile a unified overall plan of care for the patient.

So, does that help?

Heather Baker: Yes. Thank you.

Operator: Your next question comes from the line of Sharon Kimball.

Nancy Heston: This is Nancy Heston from Providence Portland Medical Center in Portland, Oregon. And I just had kind of – kind of a comment, a general comment. I've listened to a lot of these presentations.

We just listened to one from Noridian a couple of weeks ago. And it would be really helpful in terms of, for me, is that when you read what we need to do, if you could give us concrete examples of someone that's done what it says. Because that's where I get confused, when it tells you – like medical necessity – and then if it would say, for example, if you admitted a patient that had this and this and this and they did this and this and this, this would be an example of somebody that we would think was medically necessary. It would just be really helpful.

Jeanette Kranacs: Thank you. We'll consider that.

Operator: Your next question comes from the line of David Brown.

David Brown: Yes. We just have a real quick question. Can neuropsychology, when it's used occasionally, be used in meeting the three-hour rule requirement?

Susanne Seagrave: This is Susanne. No. It is not one of the four core therapies used to demonstrate the intensive rehabilitation therapy requirement, though we know that it is very important for IRF to provide that service when it is needed. Certainly, many IRF patients do need neuropsychology care. It is just – that is – and let me explain a little further.

Neuropsychologists can bill separately from the IRF PPS payment. They're considered to be a type of physicians who can bill separately, and therefore they are not included in the bundled payment that we pay for to provide the intensive rehabilitation therapy services. That is why they are not included.

David Brown: Thank you.

Operator: Your next question comes from the line of Monica Scott.

Monica Scott: This is Monica Scott from National Park Medical Center in Hot Springs, Arkansas. And my question involves medical necessity. Recently, since the first of the year, our facility has been receiving quite a few additional data requests and – for denials in the area of medical necessity. And so, in reviewing the criteria on slide 28, it appears to me that we are covering each of those five areas. Is there any additional information that you might give in regards to how to best state your medical necessity for the patient?

Susanne Seagrave: All I can say is that the slides prior to slide 28 all describe the documentation requirements that we've put in place. And we specifically put all of those documentation requirements in place to guide the facility as to how to document that the patient meets all the medical necessity criteria on slide 28. So, you know, beyond sort of laying out how we need to document it, I think – I think we could just, you know, maybe, have to work offline.

Jeanette Kranacs: Yes. We try not to get – this is Jeanette Kranacs, I apologize – we try not to get prescriptive in saying you have to use these types of forms or you have to show exactly this. We really leave it up to providers to look at each individual patient and write down the documentation as appropriate for that patient to demonstrate exactly what's necessary.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Val Daniels.

Rob Grange: Hi. This is Rob Grange from Adventist Rehab Hospital in Maryland. My question is actually about making up missed minutes. And in the November 12 training call – I think it was back in 2009, training call number 4 – you answered the question around making up missed minutes and used the example of a patient refusal and how minutes can be made up within that, you know, repeating seven-day period.

I would love for you to expound on other reasons. Are there any reasons that minutes can be made up if the minutes – if missed time is documented? Or are there only certain reasons?

Susanne Seagrave: Well, I'll start off by saying there's one very important reason why minutes cannot be made up. And that is for the convenience of the staff. We have always said that the – that scheduling cannot be based on the convenience of the staff or on, you know, need to schedule staff a certain way.

There are certain events that can happen for the patient that could necessitate missing some time and then making that time up, as you say, within the same seven-day period. It must be made up within the same seven-day period. It cannot be carried over to a subsequent week.

But for example – I will give you an additional example. As you said, one example is a patient refusing to participate in the therapy. Another example could be, that we have heard about, is one time the patient needed to meet with their lawyer about something – about some issues. And they skipped an hour of therapy and made it up the next day. That is – that was simply unavoidable because the patient needed to meet with her lawyer.

Another example that we've heard about is the patient's family unexpectedly comes into town one day and interrupts the therapy. And, certainly, you know, if the patient – especially if the patient's family is from out of town, we understand that the patient would understandably prefer to spend time with their family. So, there are certain unusual things that could happen in the patient's life or the patient's course of therapy, that we would deem it acceptable to miss a little bit of that therapy on one day to make up on the next.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Elan Melamed.

Elan Melamed: Yes. Hi. Elan Melamed, Mitchell Rehabilitation Hospital in New Port Richey, Florida. I just wanted to – because my other question was already answered – a lot of the questions that have been asked sound like there are

going to be a follow-up through e-mail, and I wanted to know if all those responses can be shared with everybody on the call?

Susanne Seagrave: What we would likely do is, if we find a substantial number of people are asking a certain question, we would post additional clarifications on our Web site. Again, we have a Coverage Requirements page on the IRF PPS Web site. That is actually where this slide presentation is currently located. And we have a series of clarifications posted there. And we will develop new ones if there are particular issues like this that need to go out to everybody.

Leah Nguyen: Thank you.

Operator: And your next question comes from the line of Lindy Curry.

Lindy Curry: Hi. Lindy Curry, Murray-Calloway County Hospital in Kentucky. My question is regarding the pre-admission screening, slide number 16, where it talks about the licensed or certified clinician conducting the screening. Could you – could you give some examples of a licensed or certified clinician in your definition? And why would a licensed practical nurse or licensed vocational nurse not be a licensed or certified clinician?

Susanne Seagrave: This is Susanne again. We have never provided any kind of list of what counts or does not count as a licensed or certified clinician for completing the pre-admission screening. We feel that any such list would never be able to be comprehensive and would quickly be outdated – out of date because the designations change so often. So we do not provide any kind of list.

What we emphasize is, on slide – which slide is it? On slide 10, the licensed or certified clinician must be appropriately trained and qualified to assess the patient's medical and functional status, assess the risks for clinical and rehabilitation complications, and assess other aspects of a patient's condition, both medically and functionally. That – whether an individual or licensed or certified clinician or individual can perform those functions – is something that we – that's what we require. And that's something that needs to be determined by the IRF.

Jeanette Kranacs: Let's go back to your specific example. I believe that the two that you mentioned were ones that we would – which ones did you mention? I'm sorry.

Lindy Curry: A licensed practical nurse or licensed vocational nurse. They're the same thing, just called different in different places.

Leah Nguyen: Hold on for one moment.

Lindy Curry: Sorry?

Jeanette Kranacs: OK. I apologize for the delay. You know, as Susanne suggested, we don't want to go through that list. You know, licensing varies from area to area. State licensures can change. And that's one of the reasons why we don't want to come up with a list, because it wouldn't be comparing apples to apples.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Michelle Cardinale.

Michelle Cardinale: Hi. This is Michelle Cardinale from St. Luke's in Bethlehem, Pennsylvania. I had a question to further clarify the group therapy. You said that group therapy serves as an adjunct. And I was wondering if you could define adjunct for me? Is that a percentage of time of the three hours a day? Or, you know, how would you define that?

Susanne Seagrave: No. We have not provided a percentage of time. We have said clearly in our clarifications it could not be the preponderance of therapy provided to a patient. And we do not define the word "preponderance" other than I – you know, what the word preponderance means.

Michelle Cardinale: OK.

Susanne Seagrave: It cannot be the preponderance of therapy time provided [to] the patient. It must be well-documented in the patient's medical record why they benefit from – the particular reasons why they'd benefit from that particular amount of group therapy that's given.

The word “adjunct” means that it should, generally, be provided above and beyond the one-on-one individualized therapies. However, we have said it can count for the intensive rehabilitation therapy requirement as long as it is not the preponderance, and as long as it is well-documented why the patient benefits from the particular modality provided in that particular amount of time.

Michelle Cardinale: OK. OK. Thank you.

Operator: Your next question comes from the line of (David Pitt). (David), your line is open.

That question has been withdrawn. Your next question comes from the line of Wilma Geisendorfer.

Wilma Geisendorfer: Yes. My question is team conference. Sometimes, we get patients in, like, late Thursday night and we team conference people, Monday, Wednesday, Friday. So, maybe the therapist hasn't all seen the patient on a Friday morning. Is it OK to conference them on Monday, which would be, you know, past the four days?

Susanne Seagrave: Again – and we have a slide that we presented earlier on this. This is Susanne again. We have a slide that – the first team meeting does not have to occur in the first four days. Some people have mistakenly thought that it has to occur in the first four days in order to establish the overall plan of care. And that is not correct.

The physician him or herself can establish the overall plan of care, you know, essentially by themselves, although we hope and encourage and, you know, strongly encourage the physician to collaborate with others on developing that

overall plan of care. But the first team conference for the patient does not have to occur in the first four days. It has to occur in the first week.

Wilma Geisendorfer: OK. Thank you.

Jeanette Kranacs: That appears on slide 23.

Wilma Geisendorfer: Thank you.

Operator: Your next question comes from the line of Kevin Platt.

(Brenda): Hi. This is (Brenda) with Kevin Platt at MedStar Good Samaritan Hospital. My question is regarding the rehabilitation physician and the IOPC. In your 11/12/10 follow-up conference call, you clarified that the rehab physician doesn't have to write out or dictate the entire plan. He can use physician extenders. But that plan has to build off of the HMP and the PAPI. And it develops – it can be developed with his approval and signature. PGY-2s, 3s, or 4s – we're part of a teaching hospital – who are in our physical medicine and rehabilitation department: Are they considered to be physician extenders, and what can their involvement be in the documentation?

Leah Nguyen: Would you hold on for one moment?

Susanne Seagrave: I'm sorry. We had to check on that because I've forgotten – I believe – although, if you want to submit a comment to our resource box, that would be best so we can get back to you. We have a specific definition of physician extenders that is defined in section 1861, S as in Sam, 2, K as in kangaroo of the Social Security Act. And I do not believe that definition includes residents. But we'll have to go back to check on that for you.

(Brenda): Alright, should I send that – should I submit that question to the IRFCoverage@cms.hhs.gov?

Susanne Seagrave: Correct.

Kevin Platt: OK. Thank you.

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

Mary Wheatley: Hi. We were wondering – in the IRF-PAI training manual of 2004, there is discussion – there is – it’s written in there that your IRF-PAI discharge date does not have to match the discharge date of the patient in certain situations when the patient has completed their rehab stay but to no fault of the IRF, they are waiting on discharge, they can’t find placement.

Now, the 2012 IRF-PAI training manual doesn’t leave – it doesn’t say that explicitly. It’s left that entire sentence out.

I’ve recently gone to a UDS seminar, and they said that the best performers of IRF discharge patients from the IRF-PAI before they discharge from the facility if they’re having trouble finding placement. What are your thoughts on that?

Jeanette Kranacs: You pointed out one of the updates that we’ve made to the 2012 version of the manual. And, at this point in time, we have removed that sentence because we do believe that it’s appropriate to have those discharge dates match so that we can appropriately collect the information for the time period that the person is in the IRF.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Della Abboud.

Della Abboud: Hi. This is Della Abboud from St. Luke’s Rehab Hospital. My question is, in terms of the team conference and the participants in the team meeting, can the OT and PT disciplines be represented by COTAs or PTAs instead of OTs and PTs?

Susanne Seagrave: Again, that is covered in one of our clarifications on our Coverage Requirements Web site, which is on the IRF PPS – the Medicare IRF PSS

Web site. And the answer is no. At least to the extent, what we said was that the state licensure laws that we are aware of so far do not allow COTAs and PTAs, that is, certified occupational therapy assistants and physical therapy assistants.

They are – state licensure laws for them do not allow them to perform the functions listed as the mandatory functions at the interdisciplinary team meetings that are listed on slide – hold on one second – they are listed on slide 43.

So the types of assessing the individual progress towards goal, assessing the validity of the rehab goals, considering possible resolutions, and monitoring and revising the treatment plan – there are lots of assessment and treatment plan development requirements in there that state licensure laws simply, typically, at least the ones we are aware of, do not allow COTAs and PTAs to perform those functions.

Della Abboud: So if our state allows that, then we still cannot use – utilize those people in the team meetings?

Susanne Seagrave: If your state licensure laws allow those COTAs and PTAs to perform all of those functions independently, that's the key. If the state licensure laws allow them to perform those functions independently, then we believe that they could represent those therapy disciplines. But it must be – it must be specifically allowed within the state licensure independently.

Jeanette Kranacs: And, again, just as an example, with the registered nurse and the LPN earlier, if the COTA or the PTA have the most experience with the patient and it would be beneficial for them to be at the meeting in addition to the PT or the OT, that would certainly be preferable. But again, in addition to – if they are not independently able to meet those requirements.

Susanne Seagrave: Yes. I want to add, you know, typically – typically, what the question that we have been asked is if the COTAs and PTAs can take notes at the meeting and take that back to the therapist. And that is not allowed because that is not

truly having an interdisciplinary team meeting where all of the relevant disciplines are at the table discussing the patient's goals and problems and treatment plan, et cetera. So that is why the participants at the team meeting must be able to perform all of these functions, so that they can fully participate in the team meeting.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Ginger Castleberry.

(David): This is (David) calling from Valir Rehab in Oklahoma City. My question is, with the 36-hour situation that has – that the eval has to be done – if a physician orders physical therapy and occupational therapy, and if the PT does the eval within the first 36 hours, does that mean both disciplines within that 36? Or, can one do it after the 36 hours if one has initiated it?

Susanne Seagrave: Well, again, the – our requirement is that – is that the intensive rehabilitation therapy requirement starts no later than 36 hours from midnight of the day of admission. It – we were not prescriptive as to what that initial plan of care – what therapies that initial plan of care has to include, because it's going to depend on the needs of the patient, the individual needs of the patient.

However, you need to get all of the required intensive rehabilitation therapy requirements met within the first week. And if you are, you know – if that – if you're going – if you're only providing one hour of therapy on that third day, you're going to run into problems meeting the intensity of therapy requirement for the first week.

(David): OK.

Leah Nguyen: Thank you.

Operator: Your next question comes from the line of Mike Ellis.

Mike Ellis: Good afternoon. I have a question concerning (inaudible) slide number 10 as well. I understand a list is not provided of who, in terms, are qualified as pre-screeners. What is the role of the medical director in determining the qualifications of an individual to perform prescreening?

Susanne Seagrave: Well, of course, we – again, we’re not prescriptive as to necessarily how the decision is made. But I would, in most – the vast majority, if not all cases – assume that the medical director is making the decision on the personnel that are qualified to care for patients in the IRF, and are qualified to treat patients, and are qualified to do assessments, and are qualified – and as one of those – the medical director, I would assume, is responsible for designating who is appropriate for performing the pre-admission screening.

Mike Ellis: OK. Thank you very much.

Operator: Your next question comes from the line of Joanne Agnew.

Joanne Agnew: Yes. This is Joanne Agnew from Mercy Fitzgerald Hospital. I just had a question about the plan of care and the expected therapy. If the intensity, frequency, and duration was placed in the physician’s – and like initial – admission orders, would that meet the requirement? Or, does it have to be on the plan of care?

Susanne Seagrave: This is Susanne. It is one of the requirements of the overall plan of care. If the physician wants to reference back to the other documents of – one of the things that we have repeatedly said is that we are not expecting people to rewrite things over and over and over and over again. They can certainly reference back to, you know, the expected therapy is detailed on page whatever of such and such document.

Joanne Agnew: Thank you.

Operator: Your next question comes from the line of Cheryl Kettinger.

Cheryl Kettinger: Hi, Susanne. I actually only have a few questions now that a lot have been addressed. But just starting with the brief exceptions policy that you reference – and I know a question was asked earlier where you gave some great detail about other unique situations that would warrant the ability to do missed minutes. But in the circumstance of a patient, for instance, having a follow-up visit with a neurologist or a surgeon that they had come from their service prior – we are a freestanding facility, Magee Rehab in Philadelphia –and was curious as to whether something like that – and not always is the patient detained the entire day. We make every effort to make up that time and make sure the patient gets the full therapy that day. But would that be a situation that would warrant missed minutes within the next seven – or within that same seven-day timeframe?

Susanne Seagrave: Again, let me make sure I understand the question. So the patient is having a follow-up visit from a neurologist or some other kind of physician or treatment?

Cheryl Kettinger: Yes. Someone who is actively involved in the patient's care, I mean, it might be to re-evaluate even weight-bearing statuses, it might be to re-evaluate bracing that the patient came in, PLSLs...

Susanne Seagrave: Well, that could be – that, certainly, could be a reason for missed minutes that could be made up on a – on a subsequent day. We even said, for things like – in my mind – and the other clinicians in the room can interject here – but in my mind, that's sort of similar to having a diagnostic test performed ...

Cheryl Kettinger: Yes.

Susanne Seagrave: ... or something. And we have – and we have actually said if the – if the IRF is expecting, for example, that the next day, a patient might have to have a diagnostic test performed or might have to have a follow-up visit with a neurologist or whatever, that the IRF can actually add some minutes to the previous day...

Cheryl Kettinger: Yes.

Susanne Seagrave: ... to, you know, pre-make up, for the missed time. They can make up for the missed time the day after as well as, I think, with the brief exceptions policy. Depending on how intensive the visit is, it could potentially fall under the example of unexpected clinical events.

If it's not – if it's not a plan, just for some reason, the patient, you know, needs to have a visit all of a sudden because they – you know, they're having some sort of problem or issue that was unexpected, that could fall into the brief exceptions policy. But then, under the brief exceptions policy, that time does not necessarily have to be made up.

Cheryl Kettinger: OK.

Susanne Seagrave: But again, that's for unexpected clinical events that might happen. If it's an expected event, a planned visit, so forth, then that time does need to be made up either before or after the...

Cheryl Kettinger: OK. All right. Because that is something that we've been active with – because if it's unexpected, we use medical necessity justification, of course, because it's a new issue. But for medical management, if they're actively involved in their plan, even if we know that there's a follow-up visit, yes, we do everything we can prior to, but post-, I think sometimes setting that delineation of expected versus unexpected when it's an active – I mean, as part of, for instance, the team conference expectation of your treatment plan and addressing any problems that are impeding the progress, of course, sometimes weight-bearing or any of the restrictions that were placed post-op might – or post-treatment in the acute hospital – that even though they are able to participate actively and meet all the requirements, that would help enhance them and improve upon their progress.

So I think that is a struggle that we have. Gives a little clarification and, I guess, further clarification would be helpful as well...

Susanne Seagrave: You can certainly send the question to the resource mailbox. And...

Cheryl Kettinger: Sure. Thank you. I appreciate that. And just one other quick question, too – about – in slide 39, where you are talking about physician face-to-face visits. I know that you mentioned in there about the comprehensive assessment of the patient’s functional goals and progress in light of the medical condition.

Is that – can you elaborate a little bit about what the expectation is? Is that expected upon every face-to-face visit? Or, is that something that, you know, as long as that’s actively being done throughout – I mean, face-to-face is doing full physical exams as well as medical management, are you expecting documentation from the physician specifically on the patient’s therapy progress on a – at every progress note?

Susanne Seagrave: Every one of the minimum three physician visits per week must be comprehensive. And they must address the patient’s medical and functional goals or – you know – and functionals goal and progress in light of their medical condition. So, every one of the minimum three physician visits per week must be that comprehensive. Outside of that, they don’t have to be that comprehensive.

Cheryl Kettinger: OK. Thank you.

Leah Nguyen: Holley, we quickly, we have time for one final question.

Operator: All right. Your final question comes from the line of Chris Kane.

Chris Kane: Hello.

Susanne Seagrave: Hello?

Chris Kane: This is Chris Kane from Catholic Health in Buffalo, New York. I have a question regarding where a patient can be admitted from. Early in the presentation, you talked about coming from an acute hospital. And I wonder, in situations where, for example, a patient, may have gone to a nursing home for sub-acute rehab and returned to the hospital and stabilized in the emergency department for an exacerbation of a medical condition. Can the

patient be admitted from the ED if they have been in the hospital within the last 30 days?

Susanne Seagrave: This is Susanne. Our requirements do not speak to where a patient can be admitted from. As long as the patient meets all of the requirements for admission, all of the coverage requirements that we've laid out here, we do not have requirements indicating where a patient has to be admitted from.

Chris Kane: OK. I just wanted to clarify that. Thank you.

Additional Information

Leah Nguyen: Thank you.

Unfortunately, that is all the time we have for questions today. If we did not get to your question, you can e-mail it to us at IRFCoverage@cms.hhs.gov. That e-mail address is also listed on slide 47.

We would like to thank everyone for joining us and for your participation in the question and answer portion of the call.

On slide 48 of the presentation, you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous and strictly confidential.

I should also point out that all registrants for today's call will receive a reminder e-mail from the CMS National Provider Calls Resource Box within two business days regarding the opportunity to evaluate this call. You may disregard this e-mail if you have already completed the evaluation. Please note, evaluations will be available for completion for five business days from the day of today's call. We appreciate your feedback.

An audio recording and written transcript of today's call will be posted soon to the CMS Fee-For-Service National Provider Calls Web page.

Again, my name is Leah Nguyen, and it has been my pleasure serving as your moderator today.

I would like to thank our subject matter experts Gwen Johnson, Susanne Seagrave, and Jeanette Kranacs for their participation.

Operator: Thank you for your participation in today's call. You may now disconnect.

END