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## New Requirements For Inpatient Rehabilitation Facility Services Begin January 1, 2010

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On October 23, 2009, the Centers for Medicare and Medicaid Services (CMS) released a transmittal that detailed changes for coverage of inpatient rehabilitation facility (IRF) services. Several new changes were outlined that will affect discharges made on or after January 1, 2010, by IRFs, both freestanding rehabilitation hospitals and rehab units that are subproviders of acute care hospitals. The October 23rd transmittal outlines new instructions that replace the existing instructions found in Chapter 1, section 110 of Pub. 100-02, the Medicare Benefit Policy Manual, regarding the coverage requirements adopted in the fiscal year (FY) 2010 final rule.<sup>1</sup>

### Key Policy Changes

Under the new IRF coverage policy, several new requirements are now mandatory as part of the patient admission process and ongoing recordkeeping. These new requirements must be followed in order for a patient admission to be considered reasonable and necessary by CMS. The new policy provides documentation processes that will enable CMS to more closely audit distinctions as to when an individual will no longer meet the requirements for IRF services. Under the new policy the major manual revisions are as follows:

- **Required Preadmission Screening.** A preadmission screening must be performed within 48 hours of admission to the IRF by a certified clinician outlining the patient's condition and need for IRF services. The preadmission screening must comprehensively document specific care that will be required in addition to the patient's prior function level and the expected level of improvement. While the preadmission screening can be performed by various certified healthcare professionals, a licensed physician with rehabilitation experience must concur with the preadmission screening prior to admission. "Trial admissions" where patients are admitted for three to 10 days to determine whether they will benefit from IRF

services are no longer considered reasonable and necessary; all patients must be properly screened to assure IRF care is appropriate.

- **Required Post-Admission Physician Evaluation.** Within 24 hours of admission, a rehabilitation physician must perform an evaluation to assess the interdisciplinary team that will be involved in the patient's care, to establish the patient's diagnosis, to determine any change in the patient's condition, and to ensure continuity with the preadmission data. Where there are discrepancies between the preadmission screening and post-admission screening, CMS has outlined general guidelines as to whether the patient can continue care in the IRF or must be discharged to a different facility.
- **Required Individualized Overall Plan of Care (POC).** Within the first four days of admission, the patient's POC must be completed with detail of the patient's medical prognosis, anticipated interventions, functional outcomes, and anticipated discharge location. Anticipated interventions must note the frequency, duration, and intensity for physical, occupational, and speech rehabilitation needed. A rehabilitation physician must be responsible for writing the overall POC defining the interdisciplinary team of health professionals.
- **Required Admission Orders.** Admission orders must be generated and documented in the patient's chart by the physician upon admission.
- **Required Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI).** CMS requires that the IRF Patient Assessment Instrument forms be included in the patient's medical record in either electronic or paper form and must properly correspond to the care determined in the IRF medical record.
- **Inpatient Rehabilitation Facility Medical Necessity Criteria.** In addition to the criteria listed above, the patient chart must contain documentation that the following criteria were met at the time of admission: (1) the patient must be scheduled to receive multiple rehabilitation services, of which one service must be physical or occupational therapy; (2) the patient must meet minimum rehabilitation requirements, which generally includes three hours of rehab services per day for at least five days per week, or 15 hours of intensive services over a seven-consecutive day period; (3) the patient must be reasonably expected to actively participate in and benefit from the rehabilitation plan outlined at the time of admission; and (4) the patient must require physician supervision by a rehabilitation physician defined as a physician with specialized training and experience in inpatient rehabilitation where there must be at least three weekly documented face-to-face visits with a treating rehabilitation physician.
- **Multiple Therapy Disciplines.** At the time of admission, the patient chart must document the need for an active and ongoing interdisciplinary approach for intensive rehabilitation; the need for only one discipline will not necessitate the need for IRF services. There must be documentation that the following health professionals are involved in the patient's care and that a weekly team conference is conducted by these individuals: (1) a rehabilitation physician (or other physician with specialized training); (2) a registered nurse with specialized rehab training or experience; (3) a social worker or case manager; and (4) a licensed or certified therapist from each rehabilitation discipline involved in the patient's care.
- **Intensive Level of Rehabilitation Services.** Documentation must be contained in the chart that describes the intensity level and services provided that uniquely qualify the patient for IRF services. Specific considerations include specific hours of required rehab care (as noted above) along with documentation that therapy began within 36 hours of midnight from the day of admission.
- **Definition of Measurable Improvement.** Discharge planning must begin upon admission along with defining the expectations for patient improvement. While discharge to home or the community-setting is typically recognized as the end goal, achieving total self-care alone will not necessitate the need for continued

IRF services. Documentation must show the patient is making functional improvements that are ongoing and sustainable in relation to when treatment began.

Effective with IRF discharges on and after January 1, 2010, Medicare Administrative Contractors must use the updated coverage policy in the medical review of IRF claims. This will not affect the documentation needed to file an IRF claim or to receive payment, but CMS may apply these provisions to retrospectively deny previously-paid claims based on inadequate documentation, which denials, if sufficient in number, may ultimately threaten the IRF's status as exempt from the inpatient prospective payment system.

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<sup>1</sup> 42 C.F.R. 412.622(a)(3), (a)(4), and (a)(5), as amended in the Federal Register (74 Fed. Reg. 39762, August 7, 2009).

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