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Inpatient Rehabilitation Facility: Benefit, Coverage and Documentation

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Today's Presenters

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Objective

- This session is intended to strengthen your understanding of Medicare's IRF benefit as well as coverage and documentation requirements

Agenda

- IRF General Information and Classification Criteria
- IRF Benefit and Requirements
- Coverage
- Documentation
- COVID-19 PHE: IRF Waivers and Flexibilities
- Common Denials
- Resources
- Questions

IRF Benefit, Coverage and Documentation

Inpatient Rehabilitation Facility (IRF)

- IRF hospital or IRF unit of a hospital
  - Excluded from the IPPS (SSA Section 1886 (j))
  - Eligible for payment if it meets all criteria specified in 42 Code of Federal Regulations (CFR) – Sections 412.25 and 412.29
  - IRF is reimbursed via IRF PPS: RICs and CMGs
    - Medicare Payment Systems: IRF PPS
  - Criteria an IRF must have
    - Provider agreement to participate as hospital or part of a hospital must be in effect

Inpatient Rehabilitation Facility (IRF)

- Prior to 10/1/ 2019, is not excluded in its entirety from PPS; unless it is a unit in a CAH
- At least 10 staffed and maintained hospital beds that are paid under applicable payment system under which the hospital is paid, or at least 1 staffed and maintained hospital bed for every 10 certified inpatient rehabilitation facility beds, whichever number is greater
  - Otherwise, the IRF will be classified as an IRF hospital, rather than an IRF unit
- Written admission criteria that is applied uniformly to both Medicare and non-Medicare patients

Inpatient Rehabilitation Facility (IRF)

- Admission and discharge records must be separately identified from those of hospital in which it is located and are readily available
- Policies specifying that necessary clinical information is transferred to the unit when a patient of the hospital is transferred to the unit
- Utilization review standards applicable for the type of care offered in the unit
- Beds are physically separate from (not commingled with) hospital's other beds
- Be serviced by the same MAC as the hospital

Inpatient Rehabilitation Facility (IRF)

- Be treated as a separate cost center for cost finding and apportionment purposes
- Use an accounting system that properly allocates costs
- Maintain adequate statistical data to support the basis of allocation
- Report its costs in the hospital's cost report covering the same fiscal period and using the same method of apportionment as the hospital
- As of first day of first cost reporting period for which all other exclusion requirements are met, the unit is fully equipped and staffed and is capable of providing hospital inpatient rehabilitation care regardless of whether there are any inpatients in IRF unit on that date

IRF Presumptive Compliance Criteria

- To receive the additional payment and status as an IRF, the facility must have treated least 60% of its total inpatient population for one or more of 13 conditions
  - Condition are listed in 42 CFR 412.29(b)(2) and CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 140.1.1
  - This includes comorbidities and subconditions
    - Additional information: CMS: Specifications for Determining IRF "60% Rule" Compliance

IRF Presumptive Compliance Criteria

- If the facility fails the presumptive compliance criteria, the MAC must use the medical review methodology to determine whether or not the IRF can retain its payment status under the IRF prospective payment system for the upcoming start of the IRF's next cost reporting period
- CMS IRF Data Files

Did You Know?

- Inpatient rehabilitation facility (IRF) benefit
  - 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 an and an interdisciplinary team approach to the delivery of rehabilitation care
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110

CMS Medicare IRF Benefit

- IRF benefit provides
  - Intensive rehabilitation therapy in a resource intensive IP hospital environment
  - Interdisciplinary team approach
- IRF patient must
  - Require and reasonably be expected to benefit from IP stay and interdisciplinary team approach due to complexity of their nursing, medical management, and rehabilitation needs
    - Able to actively participate in/benefit from IRF program

IRF Services

- IRF must furnish using qualified personnel
  - Rehabilitation nursing
  - PT
  - OT
  - SLP, as needed
  - Social services
  - Psychological services
    - Including neuropsychological services
  - Orthotic and prosthetic services

Medical Supervision is Required

- Rehabilitation physician
  - Licensed physician with specialized training and experience in IP rehabilitation to assess patient both medically and functionally, as well as to modify course of treatment as needed to maximize patient's capacity to benefit from rehabilitation process

Medical Supervision is Required

- Rehabilitation physician must
  - Conduct face-to-face visit with each patient at least three days per week during the first week of patient's IRF stay
    - Week two and beyond: One of the three days may be delegated to a qualified NPP
      - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110.2, Item 4
  - Assess patient medically and functionally
  - Modify treatment plan as needed to maximize patient's capacity to benefit from rehabilitation process

Physician Orders

- All physician orders must be documented, signed, and dated by rehabilitation physician
- Admission orders must be generated at time of admission
  - Must be documented, signed, and dated by rehabilitation physician
    - Note: To reduce duplicative documentation requirements, CMS-1688-F removed admission order documentation requirement from IRF payment regulation(s)

Physician Certification/Recertification

- Must be signed and dated and include
  - Reason for IP services
  - Estimated IP time patient anticipated to need
  - Plans for post hospital care (when needed)
  - **Note:** Documentation that IRFs are already required to complete to meet IRF coverage requirements** may be used to satisfy certification and recertification statement requirements

    ** Examples: Preadmission screening (including physician review and concurrence) and required admission orders

Preadmission Screening

- Preadmission screening is a key factor to identify appropriate patients for IRF services
  - Is an evaluation of patient's condition and need for rehabilitation therapy and medical treatment
  - Serves as detailed comprehensive review of patient's condition and medical history
  - Document patient's status prior to admission and specific reasons that led your clinical staff to conclude IRF admission is R and MN

Preadmission Screening

- Must be conducted and completed by qualified licensed or certified clinician (designated by rehabilitation physician) within 48 hours immediately preceding IRF admission
  - Conduct in person or through review of patient's referring hospital medical records when hospital stay precedes IRF admission
  - Note: Appropriately completed preadmission screening completed more than 48 hours before admission must include an update within 48 hours immediately preceding IRF admission
    - Include patient's medical and functional status

Preadmission Screening

- Documentation must include patient's:
  - Prior level of function
    - Clarification: Prior to event/condition leading to current need for intensive rehabilitation therapy
  - Expected level of improvement as well as expected length of time necessary to achieve that level of improvement
  - Evaluation of risk for clinical complications
  - Conditions that resulted in need for treatment
  - Specific treatments needed
  - Anticipated discharge destination

Preadmission Screening

- Preadmission screening documentation must be signed, dated and timed by rehabilitation physician prior to IRF admission

History and Physical

- Physician's history and physical is required under the CoP (42 CFR Section 482.24[c][4][i][A])
  - Include patient's medical history and current list of medications
- Post-admission physician evaluation (PAPE)
  - No longer required
    - **Note:** The PAPE was previously required pursuant to 42 CFR Section 412.622(a)(4)(ii), was removed in FY 2021 IRF PPS Final Rule (85 FR 48424)

Individualized Overall Plan of Care (POC)

- Rehabilitation physician, with input from all interdisciplinary team members, develops patient's expected course of treatment (POC) which generally includes
  - Be individualized to unique needs of patient based on information in preadmission screening and therapy assessments documentation
    - Consider patient's impairments, functional status, complicating conditions and any other contributing factors
  - Include medical prognosis

Individualized Overall Plan of Care (POC)

- Support that IRF admission is medically R and MN
- Include short and long-term goals
- Include anticipated interventions by PT, OT, SLP and any prosthetic/orthotic therapies individualized to patient's unique care needs
  - POC should be based on consideration of patient's impairments, functional status, complicating conditions and any other contributing factors
  - Document anticipated functional outcomes, estimated length of stay and discharge destination

Individualized Overall Plan of Care (POC)

- Clearly document by discipline the anticipated type, intensity/amount, frequency and duration of all planned therapies
  - Detail all anticipated interventions including number of hours per day, number of days per week, number of days during IRF stay
  - Avoid vague or subjective descriptions

- Rehabilitation physician is responsible for integration of information required in overall POC and for documenting it in patient's IRF medical record
  - Individual assessments by appropriate clinical staff contribute to information contained in overall POC

Individualized Overall Plan of Care (POC)

- POC is generally completed, signed and dated by rehabilitation physician within first four days of admission and must support determination that IRF stay is R and MN
  - Best practice: Complete on day one, two, three or four
- **Reminder:** Documentation already required to meet IRF coverage requirements (e.g. preadmission screening, including physician review and concurrence and required admission orders) may be used to satisfy the certification and recertification statement requirements

Individualized Overall Plan of Care (POC)

- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, section 10.2(e)

- POC must be reviewed and revised as needed
  - Include any updates to POC

Patient Assessment Instrument (PAI)

- Required: IRF-PAI
  - Used to gather data to determine payment for each Medicare Part A fee-for-service patient admitted to an IP rehabilitation unit or hospital
  - Must be completed at admission and discharge before transmission into IRF-PAI software
    - Must be dated, timed and signed
  - No longer required to be included in medical records but may be included (electronic or paper format)

Patient Assessment Instrument (PAI)

- Data collected on IRF-PAI should correspond with information in patient's IRF medical records
  - IRF-PAI must process completely at the CMS National Assessment Collection Database prior to submitting IRF claim to NGS
    - Verify by reviewing your IRF-PAI validation report
- Training manual and downloadable software
  - CMS IRF-PAI and IRF-PAI and IRF QRP Manual

IRF Quality Reporting Program (QRP)

- CMS strongly encourages submission of quality data prior to annual deadline
  - Ensures data complete and accurate and allows IRFs an opportunity to address any data submission issues
  - IRF not submitting required quality data is subject to 2% reduction in its Annual Increase Factor for applicable performance year
  - Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) and IRF QRP Training

Medical Necessity: IRF Inpatient Stay and Therapy Services

- Must be a reasonable expectation, upon admission, that patient is able to actively participate in and benefit from intensive IRF therapy program; the patient must
  - Require an intensive and coordinated interdisciplinary approach to providing rehabilitation
    - Intensive rehabilitation therapy program
      - At least three hours per day/at least five days per week
      - When well documented, intensive therapy may consist of at least 15 hours within a seven-day consecutive period

Medical Necessity: IRF Inpatient Stay and Therapy Services

- Must reasonably be expected to actively participate in and benefit from intensive rehabilitation program
- Condition and functional status
  - Can reasonably be expected to make measurable improvement, that will be of practical value to improve patient's functional capacity or adaptation to impairments, as a result of the rehabilitation treatment
  - Clarification: Patient is not necessarily expected to achieve complete independence in self-care nor be expected to return to prior level of functioning
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110.3 – Definition of Measurable Improvement

Medical Necessity: IRF Inpatient Stay and Therapy Services

- Require multiple therapy disciplines
  - PT, OT, SLP, prosthetics/orthotics
    - One must be either PT or OT
- Require physician supervision by a rehabilitation physician
  - Rehabilitation physician must be face-to-face at least three times per week to assess patient both medically and functionally; modify course of treatment as needed to maximize patient's capacity to benefit from rehabilitation process
    - Beginning week two of IRF admission: Qualified nonphysician practitioner may conduct one of the three required face-to-face visits

Medical Necessity: IRF Inpatient Stay and Therapy Services

- Reminders
  - Medical record documentation including, but not limited to, preadmission screening, POC, and admission orders must demonstrate reasonable expectation that IRF stay was medically R and N at time of admission to IRF and continue to be medically R and N during IRF stay
    - Patient requires active and ongoing therapeutic intervention of multiple therapy disciplines (one must be PT or OT)
  - Documentation per DOS must clearly indicate clinicians name, professional credentials, type and the amount (in minutes) of each therapy service provided

IRF Therapy Services

- Individualized therapy (one therapist to one patient) is standard of care for IRF
- May use on limited basis
  - Group therapy
    - When group therapy better meets patient's needs, on a limited basis, include in medical records documentation the situation/rationale justifying group therapy
  - Concurrent therapy (one therapist treating two patients performing different activities at same time)

IRF Therapy: Brief Exceptions Policy

- Brief Exceptions Policy
  - Not applicable for first 3 days after IRF admission
  - Expectation: patient needs and receives intensive IRF therapy
    - Changing patient needs may necessitate an adjustment to therapy for a limited number of days (not to exceed 3 consecutive days) during an IRF stay
      - Examples include when the patient experiences
        - » Trouble tolerating 3 hours per day;
        - » Unexpected clinical event limiting ability to participate in intensive program
        - » Or, has a medically necessary treatment or test

IRF Therapy: Brief Exceptions Policy

- Documentation when brief exceptions policy applies
  - Specify reasons for break in therapy services
  - When appropriately documented and medically necessary a brief break in therapy services does not impact medical necessity of IRF stay

IRF Therapy Services

- Initiation
  - Must begin therapy services within 36 hours
    - Count from midnight of the day of admission to the IRF
- Multiple therapies
  - Patient must be actively involved in multiple therapy disciples, one of which must be PT or OT
    - Note: If patient only requires treatment by one therapy discipline, the IRF stay is not medically reasonable and necessary

IRF Interdisciplinary Team

- Purpose
  - Foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals
- Individual members work within their own scopes of practice and must include at a minimum
  - Rehabilitation physician
  - Social worker or case manager

IRF Interdisciplinary Team

- Registered nurse with specialized rehabilitation training or experience
- Licensed or certified therapist from each therapy discipline involved in treating the patient
- Note: Therapy assistants: Not qualified to represent therapy discipline in team meetings

- Each professional also expected to coordinate efforts with team members of other specialties and with patient and patient's significant others/caregivers

IRF Interdisciplinary Team

- Members must document periodic clinical entries in medical records including patient's status in relationship to goal attainment and discharge plans
  - Conduct periodic team meetings at least once per week
  - Determine appropriateness of treatment at least once per week

IRF Patient Medical Records

- CMS expects IRF to obtain copies of previous therapy notes and retain in patient's medical records
  - IRF therapists and additional staff should use the previous therapy notes
- IRF: All IRF and previous therapy notes must be available upon request to MAC

IRF Patient Medical Records

- Medical records must reflect medical necessity of IRF admission and stay
- *Should include*

  Not intended to be an all-inclusive list

  - Physician/Nonphysician practitioner orders
  - History and physical
  - Discharge summary – hospital or other facility prior to IRF admission
  - Preadmission screening and related notes

IRF Patient Medical Records

- Signed and dated individualized POC
- IRF-PAI assessment and supporting documentation
  - Not required, but may be included, in records sent to NGS
  - Include names and professional credentials of participants
- Progress notes – signed and dated
- Medical necessity for IRF admission and continued stay
- Support for minimum required face-to-face visits
- Interdisciplinary team conference notes
  - Names and professional credentials of participants

IRF Patient Medical Records

- Therapy : Physical, Occupational and Speech-language
  - Initial and any subsequent evaluations; POC, therapy notes (singed and dated), therapy minutes logs, discharge summary
- Vital signs and weight
- Nutrition notes
- Treatment records
- Test results: Diagnostic, radiological, laboratory, pathology, as well as other pertinent test results and interpretations

IRF Patient Medical Records

- Medication administration records
  - Include dose, route and frequency
- Any notices that may have been issued – e.g. ABN, HINN, etc.
- Signature log or signature attestation for any missing or illegible signatures within medical record
  - Applies to all personnel providing services

COVID-19 PHE: IRF Waivers and Flexibilities

- 3/30/2020 – CMS-1744-IFC (interim final rule)
  - Removed IRF postadmission physician evaluation requirement during PHE
    - CMS later removed this requirement entirely effective for all IRF discharges beginning on/after 10/1/2020
  - During PHE, physician supervision requirement was changed to allow IRF physician visits to be conducted via telehealth

COVID-19 PHE: IRF Waivers and Flexibilities

- 4/30/2020 – IRF Flexibilities (CMS-5531-IFC)
  - Waives IRF "3-hour rule"
    - Patients admitted to IRF during PHE do not need to receive at least 15 hours of intensive rehabilitation therapy per week
  - Modifies IRF coverage and classification requirements during PHE when all criteria (below) are satisfied at time of admission to IRF
    - Patient admitted to freestanding IRF solely to alleviate acute care hospital bed capacity issues and IRF is located in a state experiencing a surge during PHE

COVID-19 PHE: IRF Waivers and Flexibilities

  - CMS instructed freestanding IRFs to add "**DS**" to end of unique hospital patient identification numbers (numbers that identify patients' IRF medical records) to identify patients being treated in a freestanding IRF solely to alleviate IP bed capacity in a state experiencing a surge during COVID-19 PHE

- Additional information:
  - CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110.2.6 – IRF Waivers and Flexibilities During the Public Health Emergency for the COVID-19 Pandemic

Tips

- Ensure documentation clearly shows patient's need for intensive rehabilitation therapy
  - Be accurate
  - Avoid vague or subjective descriptions
  - Ensure records reflect required three hours of intensive therapy per day at least five days per week or at least 15 hours within a seven consecutive day period with individualized therapy as standard for (subject to COVID-19 PHE waivers)
    - Limited use: group and concurrent therapy
    - Document any exceptions

Common Reasons for Denial

- Documentation
  - Requested but not received by NGS
  - Missing some required elements
    - Examples: Preadmission screening; POC; therapy notes
  - Does not support services were medically R and N
  - Does not support close physician supervision and medical management

Common Reasons for Denial

- 55F18
  - Preadmission screen was not included in the submitted documentation
  - Refer to 42 CFR Section 412.622 (a)(4)(i)

Common Reasons for Denial

- 55F35
  - Documentation does not support the patient's condition required the close physician supervision, the medical management to support the necessity of an IRF stay
  - Refer to 42 CFR Section 412.622 (a)(3)(iv), CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1 – Inpatient Hospital Services Covered Under Part A, Section 110.2

Common Reasons for Denial

- 55F39
  - Documentation does not support that upon admission a measurable improvement that will be of practical value was expected in a reasonable period of time
  - Refer to 42 CFR Section 412.622 (a)(3)(ii), CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1 – Inpatient Hospital Services Covered Under Part A, Section 110.2

Common Reasons for Denial

- 55F37
  - Documentation does not support that upon admission to the IRF the patient required multiple therapy disciplines (one of which must be physical therapy or occupational therapy)
  - Refer to 42 CFR Section 412.622 (a)(3)(i), CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1 – Inpatient Hospital Services Covered Under Part A, Section 110.2

Common Reasons for Denial

- 56900
  - Requested medical records not received within 45 day time limit; therefore unable to determine medical necessity
    - **Note:** If less than 120 days after remittance denial notification, submit records to the contractor who requested records; do not resubmit the claim

J6 and JK Medical Review

- Current TPE Review: Inpatient Rehabilitation Services
  - J6 Targeted Probe and Educate Review Topics
  - JK Targeted Probe and Educate Review Topics

Resources

CMS Resources

- Inpatient Rehabilitation Facility PPS
- Inpatient Rehabilitation Facility PPS Web Pricer
- Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP)
- Clarifications for the IRF Coverage Requirements
- MLN Fact Sheet "Complying With Medical Record Documentation Requirements"
- IRF Rules and Related Files

CMS Resources

- MLN Fact Sheet "Complying with Medicare Signature Requirements"
- CMS IOM Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110, Inpatient Rehabilitation Facility (IRF) Services
- CMS IOM Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 140, Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS)

CMS Resources

- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 3 – Verifying Potential Errors and Taking Corrective Actions, Sections 3.2.3.1 – Additional Documentation Requests (ADR); 3.2.5 – Targeted Probe and Educate (TPE) and 3.3.2.4 – Signature Requirements
- CMS IOM Publication 100-08, *Medicare Program Integrity Manual*, Chapter 6 – Medicare Contractor Medical Review Guidelines for Specific Services, Sections 6.7 – Medical Review of Inpatient Rehabilitation Facility (IRF) Services, and 6.7.1 – Reviewing for Intensive Level of Rehabilitation Therapy Services Requirements

CMS Resources

- Definition and Uses of Health Insurance Prospective Payment System Codes (HIPPS Codes), dated 4/4/2022 – IRF PPS HIPPS discussion begins on page 12
- CMS Special Edition article SE20015 Revised "New Waivers for Inpatient Prospective Payment System (IPPS) Hospitals, Long-Term Care Hospitals (LTCHs), and Inpatient Rehabilitation Facilities (IRFs) due to Provisions of the CARES Act"
- CMS Special Edition article 17036 Revised "Inpatient Rehabilitation Facility (IRF) Medical Review Changes"

CMS Resources

- Clarifications for the IRF Coverage Requirements
- Medicare Payment Systems: Inpatient Rehabilitation Facility Prospective Payment System
- CMS MLN Matters article SE17036 Revised "Inpatient Rehabilitation Facility (IRF) Medical Review Changes"

2018 OIG Report

- "Many Inpatient Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements" (A-01-15-00500)
  - OIG found that for many IRF's, medical record documentation did not support that IRF care was R & N in accordance with Medicare's requirements

NGS Resources

- NGS website
  - Resources > Medicare Compliance
    - Medical Review
    - Targeted Probe and Educate
- TPE Manual
- JK: Significant Findings for TPE Review of Inpatient Rehabilitation Facility Services (TOB 11X) – posted 1/26/2021

NGS Resources

- NGS > Resources > Compliance > Comprehensive Error Rate Testing > CERT Alerts – Examples
  - Signature Requirements
  - Physical Therapy Services
  - Hospital Discharge Summary: Insufficient Documentation Causes Most Improper Payments

NGS Resources

- Missing or Illegible Signatures/Signature Requirements
- NGS Appeals information

Thank You!

- Follow-up email
  - Attendees will be provided a Medicare University Course Code
- Questions?

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