INPATIENT REHABILITATION DOCUMENTATION AND BILLING REQUIREMENTS

I. Medicare Coverage Criteria:

IRF care is only considered by Medicare to be reasonable and necessary if, as documented in the patient's medical record, the patient meets the following criteria at the time of the patient's admission to the IRF:

A. Multiple Therapy Disciplines – At the time of admission to the IRF, there shall be a reasonable expectation that the patient requires the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics). One of the therapy disciplines shall be physical or occupational therapy.

B. Intensive level of Rehabilitation Services – At the time of admission to the IRF, there shall be a reasonable expectation that the patient requires the intensive rehabilitative therapy services that are uniquely provided in an IRF.

1. "Three Hour Rule"--The generally-accepted standard by which the intensity of services is demonstrated in IRFs is by the provision of intensive therapies at least 3 hours per day at least 5 days per week. In certain well-documented cases, an intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF, as long as the reasons for the patient's need for this program of intensive rehabilitation are well-documented in the patient's medical record and the overall amount of therapy can reasonably be expected to benefit the patient. In any case, the intensity of therapy shall be reasonable and necessary and shall never exceed the patient's level of need or tolerance, or compromise the patient's safety.

2. Start of Therapy--The required therapy treatments shall begin within 36 hours from midnight of the day of admission to the IRF. Therapy evaluations constitute the beginning of the required therapy services and may also be included in the total provision of therapies used to demonstrate the intensity of therapy service provided in an IRF.

3. Individualized Therapy--The standard of care for IRF patients is individualized (i.e. one-to-one) therapy. Group therapies serve only as an adjunct to individual therapies and may not be counted toward the requirement that patients receive at least 3 hours of intensive therapy at least 5 days per week. Group therapy is defined as either (1) a group of patients doing the same treatment with the same plan and goals or (2) overlapping treatment time of more than one patient to one therapist. In those instances in which group therapy is used on a limited basis, the rationale that justifies group therapy shall be specified in the patient's medical record at the IRF.

4 Brief Exception Policy--If an unexpected clinical event occurs during the course of the patient's IRF stay that limits the patient's ability to participate in the therapy program for a brief period not to exceed 3 consecutive days (e.g. extensive diagnostic tests off

premises, prolonged intravenous infusions of chemotherapy or blood products, bed rest due to signs of deep vein thrombosis, surgical procedure, etc) the specific reasons shall be documented in the patient's medical record. If these reasons are appropriately documented in the medical record, such a limited break in service will not affect the determination of medical necessity of the IRF admission.

C. Ability to Actively Participate in Intensive Rehabilitation Therapy – at the time of admission to the IRF, there shall be a reasonable expectation that the patient can actively participate in, and significantly benefit from, the intensive rehabilitation therapy program. The information in the preadmission screening, the post-admission physician evaluation, the overall plan of care, and the admission orders shall clearly document this expectation.

1. Significant Benefit/Measurable Practical Improvement--a patient can only be expected to benefit significantly from an intensive rehabilitation therapy program provided in the IRF if the patient's medical record indicates a reasonable expectation that a measurable, practical improvement in the patient's functional condition can be accomplished within a predetermined and reasonable period of time. The patient's medical record shall document both the nature and degree of expected improvement and the expected length of time to achieve the improvement.

2. Functional Improvement--the IRF medical record shall also demonstrate that the patient is making functional improvements that are ongoing and sustainable, as well as of practical value, measured against his/her condition at the start of treatment. The patient's treatment goals and achievements during an IRF admission are expected to reflect significant and timely progress toward the end goal of returning to the home or community-based environment.

3. Discharge Planning--discharge planning is an integral part of any rehabilitation program and shall begin upon the patient's admission to the IRF. An extended period of time for discharge from the IRF would not be reasonable and necessary after established goals have been reached or the determination has been made that further progress is unlikely.

D. Physician Supervision – at the time of admission to the IRF, there shall be a reasonable expectation that the patient's medical management and rehabilitation needs require an inpatient stay and close physician involvement.

1. Face-to-Face Visits--close physician involvement is demonstrated by documented face-to-face visits at least 3 days per week from a rehabilitation physician or other licensed treating physician with specialized training and experience in rehabilitation throughout the patient's stay in the IRF. The purpose of the face-to-face visits is to assess the patient ***both medically and functionally with an emphasis on the important interactions between the patient's medical and functional goals and progress***, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. The required rehabilitation visits shall be documented in the patient's medical record.

2. Non-Rehabilitation Physicians--Other physician specialties may treat and visit the patient, as needed; however, these visits do not count toward the rehabilitation physician requirements described above.

3. Physician Progress Notes--physician progress notes shall be legible and include documentation of medical issues, consultant coordination and functional status. At a minimum the physician progress notes shall reflect active and ongoing rehab management and document:

   (a) Coordination of medical management as it impacts the rehabilitation process i.e.; coordination of consultant services and communication with referring and primary care physicians

   (b) Coordination of the rehabilitation team process

   (c) Participation in family conference

   (d) Participation in team conference

   (e) Revisions to the anticipated plan of care

   (f) Determination of impairment/functional status

   (g) Ongoing assessment of rehabilitation services

   (h) Assessment and/or management of the plan as it relates to the rehabilitation process

   (i) Assessment of discharge status and/or needs i.e.; follow-up

E. Interdisciplinary Team Approach to the Delivery of Care--at the time of admission to the IRF, the patient shall require an intensive and coordinated interdisciplinary approach to providing rehabilitation. The documentation in the patient's medical record shall indicate that the complexity of the patient's nursing, medical management and rehabilitation needs require an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.

1. Required Disciplines--the interdisciplinary team shall document participation by professionals from the following disciplines (each of whom shall have current knowledge of the patient as documented in the medical record):

   (a) rehabilitation physician with specialized training and experience in rehabilitation services

   (b) a registered nurse with specialized training and experience in rehabilitation services

   (c) a social worker or a case manager (or both)

   (d) a licensed or certified therapist from each therapy discipline involved in treating the patient

2. Rehabilitation Physician--the interdisciplinary team shall be led by a rehabilitation physician who is responsible for making the final decisions regarding the patient's treatment in the IRF. This physician shall document concurrence with all decisions made by the interdisciplinary team at each meeting. A physician extender, NP or PA may participate in Team Conference; however, the requirement is not met if the physician is not present and participating in the team conference.

3. Team Conferences--the team conferences shall be held a minimum of once per week and focus on:

   (a) Assessing the individual's progress towards the rehabilitation goals.

   (b) Considering possible resolutions to any problem that could impede progress towards the goals.

   (c) Reassessing the validity of the rehabilitation goals previously established.

   (d) Monitoring and revising the treatment plan as needed.

4. All treating professionals from the required disciplines must attend every meeting or, in the infrequent case of an absence, be represented by another person of the same discipline who has current knowledge of the patient.

5. Documentation of each team conference shall include the names and professional designations of the participants in the team conference as demonstrated by the signature of each of the team members present at the team conference.

6. The occurrence of the team conference and the decisions made during the team conferences, such as those concerning discharge planning and the need for any adjustment in goals or in the prescribed treatment program, shall be recorded in the patient's medical record.

II. Documentation and Claim Submission Requirements:

For traditional Medicare beneficiaries, prior to billing a claim for services to Medicare, the IRF Director shall confirm that the medical record contains documentation that meets the coverage criteria established by the Medicare Benefit Policy Manual, Chapter 1, Section 110 and supported by regulatory changes found in 42 C.F.R. Section 412.622 for inpatient rehabilitation services provided in inpatient rehabilitation facilities and all of the requirement of this policy. The IRF Program Director is responsible for establishing an oversight process at the IRF to ensure that no claim is submitted to the Medicare program unless all of the requirements of this policy are met and that no claim is submitted to any other payer unless all of the requirements set forth by that payer are met.

Medical Record documentation requirements referenced in the following sections are applicable to all patients regardless of payer.

A. Required Preadmission Screening

1. Purpose--a preadmission screening is an evaluation of the patient's condition and need for rehabilitation therapy and medical treatment. The preadmission screening documented in the patient's medical record serves as the primary documentation by the IRF clinical staff of the patient's status prior to admission and of the specific reasons that led to the conclusion that the IRF admission would be reasonable and necessary.

2. Timing of Preadmission Screening--all patients shall receive a preadmission screening that is conducted by licensed or certified clinicians within 48 hours immediately preceding the IRF admission. A preadmission screening that includes all the required elements, but that is conducted more than 48 hours immediately preceding the IRF admission, is acceptable as long as an update to the original screening is conducted in person or by telephone to document the patient's medical and functional status within the 48 hours immediately preceding the IRF admission. The documentation shall be detailed and comprehensive. The review shall be done in person or through a review of the patient's acute care hospital medical record (either paper or electronic), as long as those medical records contain the necessary assessments to make a reasonable determination. A preadmission screening conducted entirely by telephone will not be acceptable without transmission of the patient's medical record from the referring hospital to the IRF and a timely review of those records by licensed or certified clinical staff in the IRF.

3. Documentation--all preadmission screening documentation (including documents transmitted from the referring hospital or other prior inpatient hospital stay) shall be retained in the patient's medical record at the IRF.

4. Licensed or Certified Clinician--referral and preadmission screening documentation shall be completed by licensed/certified clinicians who are permitted to perform assessments within their state scope of practice, have evidence of training and competency to perform preadmission screenings, and be approved by the rehabilitation physician. Individuals, regardless of clinical qualifications, assigned to business development functions such as marketing and community relations will not conduct clinical preadmission screenings for the purpose of determining if the admission criteria are met for the inpatient rehabilitation program.

5. The data collections process may be completed by an assistant (PTA, COTA or LVN/LPN, etc.). The assistant may only perform data collection and chart review activities for the purpose of providing information used by the clinician performing the preadmission screening. The qualified clinician conducting and documenting the preadmission screening shall review and approve any data collected by an assistant. The assistant may not visit with the patient and/or family, perform patient assessments, document on the preadmission screening form, or make recommendations regarding the pre–admission assessment.

6. Content—the Preadmission screening shall clearly document the following:

   (a) Indicate the patient's prior level of function (prior to the event or condition that led to the patient's need for intensive rehabilitation therapy).

   (b) Expected level of improvement and the expected length of time necessary to achieve that level of improvement.

   (c) An evaluation of the patient's risk for clinical complications.

   (d) The conditions that caused the need for rehabilitation and the treatments needed (i.e. physical therapy, occupational therapy, speech-language, or prosthetic s/orthotics).

   (e) Expected frequency and duration of treatment in the IRF.

   (f) A reasonable expectation that the patient will actively participate in, and benefit significantly from, at least 3 hours of therapy per day at least 5 days per week.

   (g) A reasonable expectation that a measurable, practical improvement in the patient's functional condition can be accomplished within a pre-determined and reasonable period of time.

   (h) Anticipated discharge destination and any anticipated post-discharge treatments.

7. Rehabilitation Physician Review—For Medicare Part A patients, all findings of the preadmission screening shall be conveyed to a rehabilitation physician prior to the IRF admission. In addition, the rehabilitation physician shall document that he or she has reviewed and concurs with the findings and results of the preadmission screening prior to the IRF admission.

   (a) Trial Admissions--"Trial" IRF admissions, during which patients were sometimes admitted to IRFs for 3 to 10 days to assess whether the patients would benefit significantly from treatment in the IRF setting, are no longer considered reasonable and necessary.

B. Post Admission Physician Evaluation

1. A Post Admission evaluation of the patient shall be performed by a rehabilitation physician (with input from the interdisciplinary team) within the first 24 hours of admission to the IRF. The purpose of the post admission physician evaluation is to document the patient's status on admission to the IRF, compare it to that noted in the preadmission screening documentation, and begin the development of the patient's overall plan of care and course of treatment. The post admission physician evaluation shall identify any relevant changes that may have occurred since the preadmission screening and shall include a documented history and physical exam, as well as a review of the patient's prior and current medical and functional conditions and comorbidities.

2. Physician documentation in the History and Physical/Post Admission Evaluation at a minimum shall include:

   (a) Medical history

   (b) Date of onset

   (c) Results of physical exam

   (d) Results of neurological exam

   (e) Prior Level of Function

   (f) Current level of function

   (g) Current medical status

   (h) Comparison to pre-admit and relevant changes

   (i) Comorbidities impacting function

   (j) Family/social history

   (k) Barriers to discharge

   (l) Medical plan

   (m) Rehabilitation plan

   (n) General rehabilitation goals

   (o) Estimated Length of Stay

   (p) Etiologic diagnosis/impairment group

3. If the post-admission physician evaluation indicates that the patient is not an appropriate candidate for IRF care due to a marked improvement in the patient's functional ability or an inability to meet the demands of the IRF rehabilitation program, the IRF shall immediately begin the process of discharging the patient to another setting. Medicare will allow the patient to continue treatment until another level of care is found; however, any IRF services provided after the 3rd day following the patient admission are not considered reasonable and necessary.

C. Required Individualized Overall Plan of Care

1. Plan of Care--in order for the IRF admission to be considered reasonable and necessary, the overall plan of care shall be completed by the rehabilitation physician within the first 4 days of the IRF admission, and it shall support the determination that the IRF admission is reasonable and necessary. The plan of care shall be updated at least weekly by each

discipline involved in the care of the patient and be maintained in the patient's medical record.

2. Content—the overall plan of care shall be based on information from the preadmission screen, the post-admission physician evaluation, and information garnered from the individualized therapy assessments. To support the medical necessity of the admission, the plan of care shall detail:

   (a) the patient's medical prognosis

   (b) the anticipated interventions (including intensity, duration, and frequency as described below)

   (c) functional outcomes

   (d) estimated length of stay

   (e) the discharge destination from IRF stay

3. Anticipated Therapy Interventions--the anticipated interventions detailed in the overall plan of care shall include the expected intensity (meaning number of hours per day), frequency (meaning number of days per week), and duration (meaning the total number of days during the IRF stay) of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies required by the patient during the IRF stay. These expectations for the patient's course of treatment shall be based on consideration of the patient's impairments, functional status, complicating conditions, and any other contributing factors.

4. Sole Responsibility of Rehabilitation Physician--Whereas the individual assessments of appropriate clinical staff will contribute to the information contained in the overall plan of care, it is the sole responsibility of a rehabilitation physician to integrate the information that is required in the overall plan of care and to document it in the patient's medical record at the IRF.

5. Discrepancies---in the unlikely event that the patient's actual length of stay and/or expected intensity, frequency, and duration of physical, occupational, speech-language pathology, and prosthetics/orthotic therapies in the IRF differ significantly from the expectations indicated in the overall plan of care, the reasons for the discrepancies shall be documented in detail in the patient's medical record.

D. Admission Orders

1. Physician Orders--a physician shall generate admission orders for the patient's care at the time of the patient's admission to the IRF. Physician orders shall be documented for Evaluation and Treatment of patients for each discipline that provides services for a patient. These orders shall be documented prior to the initiation of evaluation and treatment for therapy.

2. Clarification Orders--therapy clarification orders shall be obtained from the physician and are ongoing throughout the course of treatment.

3. Content of Clarification Orders--clarification orders shall define treatment modalities, frequency (number of days per week which cannot be defined in ranges such as "1-2 days per week", intensity (number of treatments per day – which cannot be defined by a number of minutes or hours), and duration (number of weeks of therapy – which cannot be defined by ranges such as 2 – 3 weeks). Clarification orders shall be documented directly by the physician or by the responsible therapist. If completed by the therapist they shall follow the hospital's process for telephone and/or verbal orders. Only nursing may obtain physician verbal orders for all therapy disciplines. Clarification orders shall be approved by the physician (verbal, telephone, or fax) prior to the initiation of therapy. Clarification orders shall be renewed before or at the time of expiration for continuation of the treatment ordered. The Interdisciplinary Plan of Care can serve this function provided all elements are met.

E. Inpatient Rehabilitation Facility Patient Assessment Instrument

The IRF shall maintain the IRF patient assessment instrument (IRF-PAI) forms in the patient's medical record as required by Medicare. The information in the IRF-PAI shall correspond with all of the information provided in the patient's medical record.

F. Therapy Documentation Requirements

Therapy documentation shall demonstrate the need for a qualified professional to provide for services that are of such a level of complexity and sophistication that the services can be safely and effectively performed only by or under the supervision of a qualified professional therapist.

1. Therapy Initial Assessment shall provide:

   (a) Assessment of functional status including physical status, ADL function and cognitive functions such as memory, judgment or problem solving.

   (b) Identification of problem areas to be addressed by involved disciplines.

   (c) Identification of anticipated goals in measurable terms – long and short term goals.

   (d) Identification of interventions to be utilized to progress towards identified goals.

2. Therapy Treatment Notes shall provide:

   (a) Daily documentation of exact (not rounded) time spent with each discipline included in the three hour requirement.

   (b) Identification of treatment interventions utilized to progress toward anticipated goals.

(c) Documentation of exceptions to the "three hour rule" *i.e.*, medical complications.

(d) Ongoing documentation of an individual's progress.

3. Therapy Progress Notes shall be documented weekly, at a minimum, and shall provide:

(a) Ongoing assessment of current treatment plan and progress towards/revisions to goals in measureable terms based on progress.

(b) Identification of any barriers impeding progress.

(c) Educational interventions to patient and/or family.

4. Discharge status:

Documentation shall reflect current discharge status i.e.: DME needs, current level of function and future rehabilitation needs throughout the course of treatment.

III. Medicare PPS Exempt Status:

A. In order to maintain PPS Exempt Status, at least 60 percent of admissions to the IRF must fall within the following diagnostic categories:

1. Stroke
2. Spinal Cord Injury
3. Congenital Deformity
4. Amputation
5. Major Multiple Trauma
6. Fracture Femur (hip fracture)
7. Brain Injury
8. Neurological Disorders (including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's disease
9. Burns
10. Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or

that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

11. Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

12. Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation. (A joint replaced by prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)

13. Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay, plus one or more of the following specific criteria.

    (a) The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.

    (b) The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.

    (c) The patient is age 85 or older at the time of admission to the IRF.

B. Patients admitted for inpatient rehabilitation for a condition that is not one of the 13 conditions listed above may be counted towards the applicable compliance percentage if:

1. The patient has a co-morbidity that falls in one of the CMS 13 conditions specified above; and

2. the co-morbidity has caused significant decline in functional ability in the individual such that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation and cannot be appropriately performed in another care setting.