

## **New CMS Coverage Policy for Inpatient Rehabilitation Facility Services: Are You Prepared for the Changes?**

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Effective January 1, 2010, Inpatient Rehabilitation Facilities (IRFs) began facing stricter coverage requirements. By way of a transmittal on October 23, 2009 and a revised transmittal on January 4, 2010, CMS has now revised its coverage policy found in Chapter 1, section 110 of the Medicare Benefit Policy Manual (Pub. 100-02), as mandated by the Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2010 final rule.<sup>1</sup>

The new policy imposes several additional mandatory requirements on facilities seeking coverage for IRF services. Generally speaking, the requirements are designed to ensure that the services provided are reasonable and necessary. If these requirements are not met, the services will not be considered to be reasonable and necessary, and thus will not be covered by Medicare. As such, it is important to strictly comply with the new obligations to ensure initial coverage and to avoid potentially adverse audit determinations.

### **Pre-Admission Screening**

A pre-admission screening to evaluate the patient's condition and need for IRF services must be conducted, which must specifically include the following information:

- Patient's prior level of functioning;
- Patient's expected level of improvement;
- Expected length of time necessary to achieve that level of improvement;
- Patient's risk for clinical complications;
- Specific treatments needed;
- Expected frequency and duration of the treatments;
- Anticipated destination to which the patient will ultimately be discharged;
- Anticipated post-discharge treatments that will be required; and
- Additional information relevant to the patient's care needs.

This pre-admission screening must occur within the 48 hours immediately preceding the patient's admission. This screening evaluation must be performed by a rehabilitation physician or by licensed or certified clinicians who are qualified to perform the evaluation and who are designated to do so by a rehabilitation physician. However, in all cases, a rehabilitation physician with appropriate specialized

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<sup>1</sup> 74 Fed. Reg. 39762 (Aug. 7, 2009), amending 42 C.F.R. 412.622(a)(3), (a)(4), and (a)(5).

training and experience must review and concur with the findings of the screening evaluation prior to the IRF admission.

The manual provisions also declare that “trial” IRF admissions in which patients are admitted for 3 to 10 days to assess whether a patient would best benefit from treatment in an IRF or in other settings are no longer considered reasonable and necessary, and will no longer be covered.

### **Post-Admission Physician Evaluation**

A post-admission evaluation must also be performed, which is designed to document the patient’s status after admission, compare it to that noted in the pre-admission screening, and begin to develop the patient’s expected course of treatment. The post-admission evaluation must include a documented history and physical exam, as well as a review of the patient’s prior and current medical and functional conditions and co-morbidities. The post-admission evaluation must be conducted by a rehabilitation physician, with input from all members of the interdisciplinary team who will assist in carrying out the patient’s treatment plan, within the first 24 hours following admission.

### **Individualized Plan of Care**

The patient’s record must also contain an individualized overall plan of care, which must specifically detail the following:

- Patient’s medical prognosis;
- Anticipated interventions that will be performed, including the expected intensity, frequency, and duration of each category of therapy services required;
- Desired functional outcomes; and
- Anticipated location to which the patient will be discharged following the IRF stay.

The individualized plan of care must be completed by a rehabilitation physician within the first 4 days following admission.

### **Admission Orders**

Although admission orders were always required for IRF admissions, CMS clarified that orders must be generated for each patient at the time of IRF admission and maintained in the patient’s medical record at the IRF.

### **IRF Patient Assessment Instrument (IRF-PAI)**

The IRF-PAI forms must now be included in either electronic or paper form in the patient’s medical record and must properly correspond to all other information contained in the patient’s record. In a provider training call on November 12, 2009, CMS further clarified that the IRF-PAI must have a data entry date and time.

## **Criteria for Evaluating the Medical Necessity of an IRF Admission**

In addition to the specific requirements discussed above, the new manual provisions also outline specific criteria by which the medical necessity of the proposed IRF services will be evaluated. For example, in order for the IRF care to be considered reasonable and necessary, there must be a reasonable expectation at the time of admission that the following requirements will be met:

- The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines, at least one of which must be physical or occupational therapy;
- The patient must generally require an intensive rehabilitation therapy program, which typically will consist of at least 3 hours of therapy per day at least 5 days per week;
- The patient must reasonably be expected to actively participate in and benefit significantly from the therapy program; and
- The patient must require supervision by a rehabilitation physician, and the physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay.

## **Miscellaneous**

Finally, the new manual provisions also contain additional language clarifying when IRF services, as opposed to services provided in other rehabilitation settings, will be appropriate. For example, in order to support that interdisciplinary IRF services are necessary, the complexity of the patient's condition must be such that the rehabilitation goals can only be achieved by a coordinated effort by multiple team members. The interdisciplinary treatment team must consist of, at a minimum, members from each of the following disciplines: 1) a rehabilitation physician with specialized training and experience in rehabilitation services; 2) a registered nurse with specialized training or experience in rehabilitation; 3) a social worker or a case manager; and 4) a licensed or certified therapist from each therapy discipline involved in treatment. All members of the team must meet at least once per week to reassess the patient's progress and rehabilitation goals and to modify the treatment plan as necessary.

In addition, there must be a reasonable expectation that the patient will be able to actively participate in and significantly benefit from the services rendered. In order to benefit significantly from the services, there must be a reasonable expectation that a measureable, practical improvement in the patient's functional condition can be accomplished within a predetermined and reasonable period of time. Although this does not mean that the patient must be expected to return to complete independence, the patient must be able to make functional, ongoing and sustainable improvements as measured against the patient's condition at the time the treatment began.

## Conclusion

The new coverage policy represents a significant change from prior policy and imposes significant additional detailed requirements on IRF facilities. Thus, it is important that such facilities become familiar with the new policy and adopt policies and procedures designed to ensure that all requirements are met in order to ensure initial coverage or to avoid a potential adverse audit determination. For additional information regarding the new policy or for assistance in evaluating your current compliance efforts, please contact Wachler and Associates at (248) 544-0888.



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