

Medicare Benefit Policy Manual

Chapter 1 - Inpatient Hospital Services Covered Under Part A

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110 - Inpatient Rehabilitation Facility (IRF) Services

(Rev., __-__-__)

A3-3101.11, HO-211

The inpatient rehabilitation facility (IRF) benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who suffered an acute impairment. Specifically, patients who qualify for the IRF benefit under Medicare must require, and be expected to benefit significantly from, intensive rehabilitation provided through a coordinated interdisciplinary team approach in an inpatient hospital setting. The rehabilitation needs of an IRF patient exceed the level of care that can be provided in a skilled nursing facility (SNF) or other less intensive environment.

The IRF benefit is not an alternative to acute inpatient care. A patient requiring acute inpatient care is expected to remain in the acute inpatient hospital setting, with appropriate rehabilitative treatment provided until such time as the patient no longer requires acute inpatient care. Thus, patients must have completed medical management in the acute care setting prior to admission to an IRF. Patients must not be transferred to IRFs if they have demonstrated new or acute medical problems or changes in condition just prior to discharge from the acute care hospital. If new treatment protocols have been initiated around the time of transfer, the patient must have already demonstrated an appropriate response to the treatment. IRF admissions for patients who are still in the acute phase of their illness and still require acute inpatient care will not be considered reasonable and necessary.

Conversely, the IRF benefit is not appropriate for patients who have completed their stay in an acute care hospital, do not require intensive rehabilitation, and are not yet ready to return home or to a community-based environment. Medicare benefits are available for such patients in a less-intensive setting. Inability to return home or to a community-based environment, in the absence of meeting the criteria outlined in section 110 of the Medicare Benefit Policy Manual, is not a sufficient reason for an IRF stay to be considered reasonable and necessary.

IRF care is only considered by Medicare to be reasonable and necessary under 1862(a)(1)(A) if the patient meets all of the requirements outlined in section 110 of the Medicare Benefit Policy Manual. This is true regardless of whether the patient is treated in the IRF for 1 or more of the 13 medical conditions listed in CFR §412.23(b)(2)(iii) or not.

Medicare requires determinations of whether IRF stays are reasonable and necessary to be based on an assessment of each beneficiary's individual care needs.

110.1 – Documentation Requirements

(Rev., __-__-__)

A3-3101.11.B, HO-211.B

Medicare contractors must consider the documentation contained in a patient's medical record when determining whether an IRF admission was reasonable and necessary,

specifically focusing on the preadmission screening, the post-admission physician evaluation, the overall plan of care, and the admission orders.

110.1.1 – Required Preadmission Screening

(Rev., __-__-__)

A3-3101.11.B, HO-211.B

A preadmission screening is an evaluation of the patient's condition and need for rehabilitation therapy and medical treatment that must be performed by IRF personnel within the 48 hours immediately preceding the IRF admission. The preadmission screening 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 the IRF clinical staff to conclude that the IRF admission would be reasonable and necessary. As such, IRFs must make this documentation detailed and comprehensive.

The preadmission screening documentation must indicate the patient's prior level of function, expected level of improvement, and the expected length of time necessary to achieve that level of improvement. It must also include an evaluation of the patient's risk for clinical complications, the conditions that caused the need for rehabilitation, the combinations of treatments needed (i.e., physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), expected frequency and duration of treatment in the IRF, anticipated discharge destination, any anticipated post-discharge treatments, and other information relevant to the care needs of the patient.

If the patient is being transferred from the acute care hospital, the preadmission screening may be done in person or through a review of the patient's acute care hospital medical records (either paper or electronic format), as long as the acute care hospital medical records contain the necessary assessments to make a reasonable determination. However, a preadmission screening conducted entirely by telephone without transmission of the patient's acute care hospital records to the IRF and a review of those records by licensed clinical staff in the IRF will not be accepted.

The IRF is responsible for developing a thorough preadmission screening process for patients admitted to the IRF from the home or community-based environment, which must include all of the required elements described in this section. However, such admissions will generally not involve the use of acute care hospital medical records.

Individual elements of the preadmission screening may be evaluated by any clinician or group of clinicians designated by a rehabilitation physician, as long as the clinicians are licensed (to the extent possible under State licensure laws and requirements) and qualified to perform the evaluation within their scopes of practice and training. Note that the "rehabilitation physician" referenced in the previous sentence need not be a salaried employee of the IRF but must be a licensed physician with specialized training and experience in rehabilitation. For ease of exposition throughout this document, this physician will be referred to as a "rehabilitation physician".

All findings of the preadmission screening must be conveyed to a rehabilitation physician prior to the IRF admission. In addition, the rehabilitation physician must document that he or she has reviewed and concurs with the findings and results of the preadmission screening.

All preadmission screening documentation (including documents transmitted from the acute care hospital, if applicable) must be retained in the patient's medical record.

Any IRF admission for the sole purpose of determining whether the patient can benefit significantly from treatment in the IRF or other settings is not considered reasonable and necessary. Such determination must be made through a careful preadmission screening prior to the patient's admission to the IRF.

110.1.2 – Required Post-Admission Physician Evaluation

(Rev., __-__-__)

A3-3101.11.B, HO-211.B

A post-admission physician evaluation of the patient must be performed by a rehabilitation physician, with input from the interdisciplinary team. 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 development of the patient's expected course of treatment that will be completed with input from all of the interdisciplinary team members in the overall plan of care (as discussed in section 110.1.3). The post-admission physician evaluation must identify any relevant changes that may have occurred since the preadmission screening and 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 comorbidities.

In order for the IRF stay to be considered reasonable and necessary, the post-admission physician evaluation must be completed within the first 24 hours of admission and must support the medical necessity of the IRF admission. The post-admission physician evaluation documentation must be retained in the patient's medical record.

In most cases, the clinical picture of the patient that emerges from the post-admission physician evaluation will closely resemble the information documented in the preadmission screening. However, for a variety of reasons, the patient's condition at the time of admission may occasionally not match the description of the patient's condition on the preadmission screening. This could occur, for example, if the patient's condition changes after the preadmission screening is completed. In these cases, it is important for a rehabilitation physician to note the discrepancy and to document any deviations from the preadmission screening as a result. For example, if the patient's preadmission screening indicated an expectation that the patient would actively participate in at least 3 hours of therapy per day on admission to the IRF, but the patient is only able to tolerate 2

hours on the first day due to an increase in pain secondary to a long ambulance trip to the IRF, the IRF does not have to discharge the patient. Instead, the reason for the temporary change must be noted in the patient's medical record.

In addition, the preadmission screening and the post-admission physician evaluation could differ in rare cases when a patient's preadmission screening indicates that the patient is an appropriate candidate for IRF care but this turns out not to be the case, either due to a marked improvement in the patient's functional ability since the time of the preadmission screening or an inability to meet the demands of the IRF rehabilitation program. If this occurs, the IRF must immediately begin the process of discharging the patient to another setting of care. It might take a day or more for the IRF to find placement for the patient in another setting of care. Medicare contractors will therefore allow the patient to continue to receive treatment in the IRF until placement in another setting can be found. However, in these particular cases, any IRF services provided after the 3rd day following the patient's admission to the IRF are not considered reasonable and necessary. In these particular cases, Medicare authorizes its contractors to downcode the IRF claims to the appropriate CMG for IRF patient stays of 3 days or less.

110.1.3 – Required Individualized Overall Plan of Care

(Rev., __-__-__)

A3-3101.11.B, HO-211.B

Information from the preadmission screening and the post-admission physician evaluation, together with other information garnered from the assessments of all therapy disciplines involved in treating the patient and other pertinent clinicians, will be synthesized by a rehabilitation physician to support a documented overall plan of care, including an estimated length of stay. The overall plan of care must detail the patient's medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRF stay, thereby supporting the medical necessity of the admission. The anticipated interventions detailed in the overall plan of care must 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 must be based on consideration of the patient's impairments, functional status, complicating conditions, and any other contributing factors.

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.

In the unlikely event that the patient's actual length of stay and/or the expected intensity, frequency, and duration of physical, occupational, speech-language pathology, and

prosthetic/orthotic therapies in the IRF differ significantly from the expectations indicated in the overall plan of care, then the reasons for the discrepancies must be documented in detail in the patient's medical record.

In order for the IRF stay to be considered reasonable and necessary, the overall plan of care must be completed within the first 72 hours of admission; it must support the medical necessity of the IRF admission; and it must be retained in the patient's medical record.

110.1.4 – Required Admission Orders

(Rev., __-__-__)

42 CFR 412.606

At the time that each Medicare Part A fee-for-service patient is admitted to an IRF, a rehabilitation physician must generate admission orders for the patient's care. These admission orders must be retained in the patient's medical record.

110.1.5 - Required Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)

(Rev., __-__-__)

A3-3101.11.C, HO-211.C, CFR 412.606

Medicare now requires that the IRF patient assessment instrument (IRF-PAI) forms be included in the patient's medical record. The information in the IRF-PAIs must correspond with all of the information provided in the patient's medical record.

110.2 - Inpatient Rehabilitation Facility Medical Necessity Criteria

(Rev. , __-__-__)

A3-3101.11.C.1, HO-211.C.1

In order for IRF care to be considered reasonable and necessary, the documentation in the patient's medical record (which must include the preadmission screening described in section 110.1.1, the post-admission physician evaluation described in section 110.1.2, and the overall plan of care described in section 110.1.3) must demonstrate that the following 3 criteria were met **at the time of admission** to the IRF:

1. The patient must require intensive rehabilitation, meaning that the patient must generally require and reasonably be expected to actively participate in, and benefit significantly from, at least 3 hours of therapy per day at least 5 days per week, as defined in section 110.2.1; and

2. The patient must require an intensive and coordinated interdisciplinary approach to providing rehabilitation, as defined in section 110.2.2; and
3. The patient's condition and functional status must be such that the patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the patient's functional capacity or adaptation to impairments) as a result of the rehabilitation treatment, and that such improvement can be expected to be made within a prescribed period of time. (See section 110.2.3.)

110.2.1 - Intensive Level of Rehabilitation Services

(Rev., __-__-__)

A3-3101.11.D.3, HO-211.D.3

A primary distinction between the IRF environment and other rehabilitation settings is the intensity of rehabilitation therapy services provided in an IRF. For this reason, the information in the patient's medical record (especially the required documentation described in section 110.1) must document that **at the time of admission to the IRF** the patient required the active and ongoing therapeutic intervention of at least two therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy), one of which must be physical or occupational therapy.

Specifically, to meet the intensity of therapy requirement, the documentation in the patient's medical record must show that the patient generally required and was reasonably expected to actively participate in, and significantly benefit from, at least 3 hours of intensive therapy per day at least 5 days per week. Many IRF patients will medically benefit from more than 3 hours of therapy per day, when all types of therapy are considered. The required therapy treatments must begin within 36 hours after the patient's admission to the IRF. However, the intensity of therapy provided must never exceed the patient's level of tolerance or compromise the patient's safety.

The intensity of therapy services typically required to meet the needs of a beneficiary requiring an IRF level of care is expected to exceed the intensity of therapy services provided in a SNF. For this reason, therapy services provided in an IRF must generally exceed the SNF therapy requirements. This means that an IRF patient's daily therapy requirements must generally be met by one-on-one therapy services, as documented in the patient's medical record. Group therapies are to be used in IRFs primarily as an adjunct to one-on-one therapy services.

While patients requiring an IRF stay are expected to need and receive at least 3 hours of intensive therapy per day (at least 5 days per week), this may not be true for a limited number of days during a patient's IRF stay because patients' needs vary over time. For example, if an unexpected clinical event occurs during the course of a patient's IRF stay

that limits the patient's ability to participate in at least 3 hours of therapy a day for a brief period not to exceed 3 consecutive days (e.g., extensive diagnostic tests off premises, prolonged intravenous infusion of chemotherapy or blood products, bed rest due to signs of deep vein thrombosis, exhaustion due to recent ambulance transportation, surgical procedure, etc.), the specific reasons for the break in the provision of therapy services must be documented in the patient's medical record. If these reasons are appropriately documented in the patient's medical record, such a break in service (of limited duration) will not affect the determination of the medical necessity of the IRF admission. Thus, Medicare contractors may approve brief exceptions to the intensity of therapy requirement in these particular cases if they determine that the initial expectation of the patient's active participation in intensive therapy during the IRF stay was based on a diligent preadmission screening, post-admission physician evaluation, and overall plan of care that were based on reasonable conclusions.

110.2.2 - Interdisciplinary Team Approach to the Delivery of Care

(Rev., __-__-__)

A3-3101.11.D.4, HO-211.D.4

An IRF stay will only be considered reasonable and necessary if **at the time of admission to the IRF** the documentation in the patient's medical record indicates that the complexity of the patient's nursing, medical management, and rehabilitation needs requires an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care. That is, the complexity of the patient's condition must be such that the rehabilitation goals indicated in the preadmission screening, the post-admission physician evaluation, and the overall plan of care can only be achieved through close physician involvement and periodic team conferences—at least once a week—of an interdisciplinary team of medical professionals (as defined below). Close physician involvement in the patient's care is generally demonstrated by face-to-face visits from a rehabilitation physician or other licensed treating physician with specialized training and experience in rehabilitation at least 3 days per week throughout the patient's IRF stay. The purpose of the face-to-face visits is to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.

Interdisciplinary services are those provided by a treatment team in which all of its members participate in a coordinated effort to benefit the patient and the patient's significant others and caregivers. Interdisciplinary services, by definition, cannot be provided by only one discipline. Though individual members of the interdisciplinary team work within their own scopes of practice, each professional is also expected to coordinate his or her efforts with team members of other specialties, as well as with the patient and the patient's significant others and caregivers. The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals.

At a minimum, the interdisciplinary team must document participation by professionals from the following disciplines (each of whom must have current knowledge of the patient as documented in the medical record):

- A rehabilitation physician with specialized training and experience in rehabilitation services;
- A registered nurse with specialized training or experience in rehabilitation;
- A social worker or a case manager (or both); and
- A licensed or certified therapist from each therapy discipline involved in treating the patient.

The interdisciplinary team must be led by a rehabilitation physician who is responsible for making the final decisions regarding the patient's treatment in the IRF. This physician must document concurrence with all decisions made by the interdisciplinary team at each meeting.

The periodic team conferences—held a minimum of once per week—must focus on:

- Assessing the individual's progress towards the rehabilitation goals;
- Considering possible resolutions to any problems that could impede progress towards the goals;
- Reassessing the validity of the rehabilitation goals previously established; and
- Monitoring and revising the treatment plan, as needed.

A team conference may be formal or informal; however, a review by the various team members of each other's notes does not constitute a team conference. The occurrence of the team conferences and the decisions made during such conferences, such as those concerning discharge planning and the need for any adjustment in goals or in the prescribed treatment program, must be recorded in the patient's medical record.

110.2.3 - Measurable Improvement

(Rev., __-__-__)

A3-3101.11.D.6, HO-211.D.6

An IRF admission is considered reasonable and necessary only when **at the time of admission to the IRF** 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. In general, the goal of IRF treatment is to enable the patient's safe return to the home or community-based environment upon discharge from the IRF. The patient's medical record must indicate both the nature and degree of expected improvement and the expected length of time to achieve the improvement.

For an IRF stay to be considered reasonable and necessary, the patient does not have to be expected to achieve complete independence in the domain of self-care. However, to justify the need for a continued IRF stay, the documentation in the medical record must demonstrate the patient's ongoing requirement for an intensive level of rehabilitation services (as defined in section 110.2.1) and an inter-disciplinary team approach to care (as defined in Section 110.2.2). Further, the medical record must 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. Since in most instances the goal of an IRF stay is to enable a patient's safe return to the home or community-based environment upon discharge, the patient's treatment goals and achievements during an IRF admission should reflect significant and timely progress toward this end result. During most IRF stays, therefore, the emphasis of therapies would generally shift from traditional, patient centered therapeutic services to patient/caregiver education, durable medical equipment training, and other similar therapies that prepare the patient for a safe discharge to the home or community-based environment.