Inpatient Rehabilitation Facility (IRF) Coverage & Documentation

Presented by
Palmetto GBA JM A/B MAC
Provider Outreach and Education
February 15, 2017
Disclaimer

This information is current as of February 1, 2017.

Any changes or new information superseding this information is provided in articles with publication dates after February 1, 2017, posted on our website at: www.PalmettoGBA.com/jma

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Objectives

Review Inpatient Rehabilitation Facility (IRF) coverage & documentation guidelines.

Enable providers to utilize this information to positively affect billing practices.

Maximize program protection against inappropriate payments & protect the Medicare Trust Fund.
Agenda

- Inpatient Rehabilitation Facility Services
- Documentation Requirements
- Medical Necessity Requirements
- CERT
- Stay Connected
IRF Coverage Requirements
IRF Benefit

- Patients who require and can reasonably be expected to benefit from:
  - Intensive rehabilitation therapy in an inpatient hospital environment
  - Interdisciplinary team approach to the delivery of rehabilitation care
IRF Benefit

- Cannot be used as an alternative to completion of the full course of treatment in the referring hospital
  - Full course of treatment in the referring hospital must be completed prior to transfer

- Patients must be able to fully participate & benefit from intensive rehabilitation therapy program
Documentation Requirements
Required Documentation

- Medical record documentation to support the IRF admission:
  - Preadmission screening (PAS)
  - Post-admission physician evaluation (PAPE)
  - Individualized overall plan of care (POC)
  - Physician admission orders
  - IRF-PAI included in medical record (PAI)
Preadmission Screening

- Comprehensive and accurate:
  - Conducted by licensed or certified clinician(s)
  - In person or through a review of referring hospital medical records
  - Includes detailed, comprehensive review of condition and medical history

IOM 100-02 Chapter 1; Section 110.1.1
Preadmission Screening

- Must be done timely within 48 hours
- A comprehensive screening containing all the required elements conducted 48 hours prior to admission is acceptable
Preadmission Screening

- **Must support the admission decision**
  - Serves as initial determination of whether patient meets requirements for IRF admission to be considered reasonable & necessary
  - Is used to inform rehabilitation physician who reviews & documents his/her concurrence
  - Is retained in the patient’s medical record at IRF
Preadmission Screening

- Prior level of function
- Expected level of improvement & length of time to achieve that level
- Risk for clinical complications
- Conditions that caused need for rehabilitation
- Combinations of treatments needed
- Expected frequency & duration
- Anticipated discharge destination & post discharge treatments, etc.
Preadmission Screening

- Professionals involved in preadmission screening:
  - A licensed or certified clinician must conduct the preadmission screening
    - Focus of screening review is on the quality of supplied information
    - Whether it supports decision to admit patient to IRF
Preadmission Screening

- Must support admission decision

- Serves as primary documentation by IRF clinical staff of:
  - Patient’s status prior to admission and
  - Specific reasons that led IRF clinical staff to conclude that IRF admission would be reasonable and necessary
Preadmission Screening

- Rehabilitation physician documents concurrence with finding & results
  - After preadmission screening is completed & prior to the IRF admission
  - Must either sign & date original document or
  - Sign and date a copy and fax it to IRF
Is the preadmission screening complete and accurate, and does it fully support the IRF admission decision? **NO**

The IRF admission is not reasonable and necessary

Are there any relevant changes between the preadmission screening and the post-admission physician evaluation? **YES**

Even with the changes, is the patient still expected to participate in and benefit from the intensive rehabilitation therapy program in a day or so? **NO**

The rehab physician must document the absence of changes, along with an H&P and other required information.

**NO**

Next slide...

The rehab physician must document the changes and the reason for the changes, along with an H&P and other required information.

**YES**
If, on admission, the patient no longer requires, can participate in, or can benefit from an intensive rehabilitation therapy program, the IRF must immediately begin the process of discharging the patient.

Ideally, the discharge process will take no more than 3 consecutive calendar days.

Even if the discharge process takes longer than 3 days, the IRF will only be eligible to receive the appropriate Medicare payment for IRF stays of 3 days or less.
Post-admission Evaluation

• Must be performed by the rehabilitation physician
  ◦ Ensures that rehabilitation physician sees patient in the first 24 hours of admission
  ◦ Begins development of expected course of treatment within 24 hours of admission
  ◦ Supports medial necessity of admission

IOM 100-02, Chapter 1, Section 110.1.2
Post-admission Evaluation

- Must identify relevant changes since preadmission
- Must include a history & physical exam
- Must include a review of patient’s prior and current medical and functional conditions and comorbidities
- Document any changes
- Must be retained in medical record at IRF
Individualized Overall Plan of Care

- POC must be completed within 4 days of IRF admission
- Must be sign by a rehabilitation physician
- First team meeting doesn’t have to occur within 4 days to establish overall POC
  - Although it might be good practice
  - POC is rehabilitation physician responsibility
Individualized Overall Plan of Care

- POC is individualized & based on:
  - Information from preadmission screen and post-admission physician evaluation
  - Information garnered from therapy assessments
  - Must be integrated by a rehabilitation physician

IOM 100-02 Chapter 1, Section 110.1.3
POC Required Information

- Estimated length of stay & medical prognosis
- Anticipated interventions, functional outcomes, & discharge destination
- Expected therapy
  - Intensity (# of hours per day) by discipline,
  - Frequency (# of days per week)
  - Duration (total # of days during IRF stay)
Required Admission Orders

- At the time of admission, physician must generate admission orders for patient’s care
  - Admission orders must be retained in patient’s medical record at the IRF

- Signature requirements
  - CMS IOM 100-08 Chapter 3, Section 3.3.2.4
  - Section D Signature Guidelines
  - Section E Electronic Signatures

IOM 100-02 Chapter 1, Section 110.1.4
Signatures

- Medicare Providers: What You Need to Know About Signatures & Documentation
  

- Use signature log to establish signature legibility throughout medical documentation
  - Typed listing of provider names followed by handwritten signature
  - Must also include professional credentials/titles
IRF – Patient Assessment Instrument

- IRF-PAI must be included in patient’s medical record
  - Electronic or paper format is acceptable
- PAI must include HIPPS code received from CMS repository
- Information in IRF-PAI must correspond with all of the information in patient’s IRF medical record
Validation Process for PPS Patient Assessments

- IRF PAI information
- Provider submitted HIPPS code
- HICN (IRF-PAI item #2)
- Date of birth (item #6)
- PTAN (item #1B)
- Statement From/Through dates (item #40)
- Admission date (item #12)
Validation Process for PPS Patient Assessments

- Before billing IRF claims to Medicare verify IRF-PAI validation report
  - Claim will RTP with Reason Code 37096 when incorrectly billed
- Avoid RTP by ensuring that IRF-PAI finalizes; it is error free
- Use occurrence code 50 to indicate assessment date
IRF-PAI Training Manual

- IRF-PAI Training Manual is updated each year effective October 1
  - Contains system maintenance & data transmission information

- http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/IRFPAI.html
IRF-PAI Training Manual

- FY 2016 IRF PPS Final Rule update IRF-PAI Training Manual to include changes to IRF Quality Reporting Program (QRP) Measures Information effective October 1, 2016

https://www.cms.gov/medicare/medicare-fee-for-service-payment/inpatientrehabfacpps/irfpai.html
IRF-PAI Training Manual

- Version 1.4; Section 9 includes table to easily identify which items are required, or required, if available, & voluntary
  - IRF-PAI Data Submission Specifications for item-level responses QIES ASAP submission system will accept as valid to an item for data submission starting on October 1, 2016
Medical Necessity Criteria
IRF Medical Necessity Criteria

• Physician supervision
  ◦ Demonstrated by face-to-face visits by a rehabilitation physician at least 3 days per week throughout IRF stay
  ◦ Licensed physician with specialized training & experience in inpatient rehabilitation

• Other physician specialties may treat & visit, as needed
  ◦ Do not count toward this requirement
Multiple Therapy Disciplines

- Multiple therapy disciplines; PT, OT, SLP, orthotics/prosthetics
  - IRF medical record must document patient required active & ongoing therapeutic intervention of multiple therapy disciplines
  - One of the therapy disciplines must be physical or occupational therapy

- Minimum intensity threshold for therapy services is 15 hours/week
Multiple Therapy Disciplines

- Therapy treatment schedule can vary based on patient’s medical needs:
  - Generally, 3 hours of therapy per day at least 5 days per week; or
  - At least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission
    - Reasons must be documented in medical record
Intensive Therapy Services

- Therapy treatment schedule can vary based on the patient’s medical needs:
  - Minimum 15 hours/week intensity is not met due to non-medical reasons
  - Therapy minutes must be made up during the same 7 consecutive day period starting with the day of admission
Initiation of Therapy

- Required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF
- Therapy evaluations may constitute the initiation of therapy services
- Therapy evaluations “count” for the purposes of demonstrating the intensity of therapy requirement
Group Therapy

- Group and/or concurrent therapy may not constitute the majority of therapy
  - Group therapies serve as an adjunct to individual therapies
  - Justification for use of group therapies should be documented in medical record
  - Therapy minutes cannot be rounded for purposes of documenting required intensity
Brief Exception Policy

- Example of medical reasons for exception of therapy minutes:
  - A brief exception, not to exceed 3 consecutive days, may be allowed for reduction in minimum therapy minutes/week
  - Documentation must clearly identify specific medical rationale to justify need for exception

- Intensity of therapy must never exceed level of need, tolerance or ability to participate
  - Reasonable measurable improvement expected
Brief Exceptions Policy

• Unexpected clinical events may include:
  ◦ 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
Active Participation in IRT

- There must be a reasonable expectation at the time of admission that the patient will be able to actively participate in and benefit from the intensive rehabilitation therapy program.

- Medical record must document this requirement.
Physician Supervision

- Demonstrated by the need for face-to-face visits by a rehabilitation physician or other licensed treating physician with specialized training and experience in rehabilitation at least 3 days per week throughout the IRF stay

- Documented in patient’s medical record
Interdisciplinary Team Approach

- Complexity of a patient’s needs requires an inpatient stay and an interdisciplinary team approach to care

- Purpose of the interdisciplinary team:
  - Foster frequent, structured, and documented communication among disciplines to establish, prioritize and achieve treatment goals
Interdisciplinary Team

- Rehabilitation physician with specialized training & experience in rehabilitation services
- Registered nurse with specialized training & experience in rehabilitation
- Social worker or case manager (or both)
- Licensed or certified therapist from each therapy discipline involved in treating patient
Periodic Team Conferences

- Must focus on assessing progress towards rehabilitation goals
  - Consider possible resolutions to any problems that could impede progress
  - Reassess validity of previously established rehabilitation goals
  - Monitoring & revising the treatment plan
- Must be held minimum of once per week
  - 7 calendar days beginning with day of admission
Periodic Team Conferences

- All treating professionals from the required disciplines must attend
- Documentation must be in IRF medical record
  - Include names & professional designation of participants
- Decisions during meetings must be documented
- Review of this requirement will focus on decision-making not internal processes
Measureable Improvement

- Measurable, practical improvement in patient’s functional condition
- Expected to be accomplished within a predetermined & reasonable time period
- Goal of treatment should be patient’s safe return to home or community-based environment
Measureable Improvement

- IRF medical record must demonstrate making functional improvements when measured against condition at start of treatment;
  - Ongoing, sustainable and practical value
- Emphasis of therapies generally shift from traditional, patient-centered to:
  - Patient/caregiver education
  - Durable medical equipment training; and
  - Other similar therapies to prepare for safe discharge
Discharge Planning & Dates

- Discharge planning is an integral part of any rehabilitation program & must begin upon patient’s admission to IRF
  - An extended period for discharge would not be reasonable & necessary
  - Rare cases use ABN for delayed extended period & occurrence code 76

- IRF-PAI discharge dates & IRF claim dates should match
Medical Review & CERT Review
Medical Review

- Pre-payment probe reviews ensure claims process correctly the first time
  - Decreases later recovery of payment
- Targeted reviews based on error findings
- Provider education provided to prevent future inappropriate billing
- Providers are notified of selection by ADR
CERT Review Errors

- CERT error findings = data demonstrates vulnerability & improper payment
  - Documentation didn’t support medical necessity
  - Missing required documentation
    - Preadmission screening, post-admission physician evaluation, interdisciplinary team meeting notes, plan of care developed by rehabilitation physician
  - Missing, incomplete, or illegible signature
    - Admission order to the IRF

IOM100-08, Chapter 3, Section 3.7.1.1
CERT Errors Resolution

CERT Error:  
Lacked professional credentials & consistent e-signature documentation

How to prevent:  
Rehabilitation physician must sign & date pre-admission screening before admitted

Timeliness requirement for preadmission screening not met, unqualified staff conducted screening

Conduct by a qualified licensed clinician, within 48 hours before admission & rehabilitation physician concurs prior to admission
CERT Errors and Resolution

CERT Error
Timeliness requirement for post-admission physician evaluation not completed timely

How to Prevent
Conducted by rehab physician, within 24 hours after admission & support admission is reasonable & necessary
Insufficient Documentation

Reviewer received from a provider following medical records for 8-day IRF stay:

- IRF-PAI, physician admission order to IRF, lab results, medication administration records, physician preadmission screening, MD progress notes, plan of care, discharge summary, nursing and therapy notes
Claim Review Decision

- Missing medical records from previous claim example:
  - Interdisciplinary team meeting notes
  - Post-admission evaluation/assessment
  - Purpose of post-admission physician evaluation; note patient status after admit, develop expected treatment course with input from team members
Medical Necessity Not Supported

Reviewer received following records for a 3-week IRF stay:

- PAS, PAPE, nursing progress notes, NP’s discharge summary, interdisciplinary team meeting notes, plan of care; PT, OT & SLP notes, physician’ orders from hospital, consults and progress notes;
Medical Necessity Not Supported

Reviewer also received:

- Diagnostic lab test & radiology reports, IRF-PAI, signature log & electronic signature protocol
- Inpatient hospital admission record showed patient IRF stay was interrupted one day
Claim Review Decision

- Missing medical records from previous claim example:
  - Physician IRF admission order

- Legible physician orders must be retained in patient’s medical record at the IRF
  - Use a signature log or attestation for illegible signature; follow electronic signature protocol for e-signature
Medical Necessity Not Supported

Reviewer received the following medical records for a 14-day IRF stay

- PAS, PAPE, IRF orders, PT/OT/SLP evaluations & plans, daily therapy/care notes, physician progress notes, discharge planning, team meeting notes, IRF-PAI
Claim Review Decision

- Missing medical records from previous example:
  - Plan of care integrated by rehabilitation physician
- An individual plan of care is required to combine information in the preadmission screening, post-admission assessment, therapy evaluations & notes to show overall plan of care for the patient
Inpatient Rehabilitation Facility PPS

To view the most recent postings, see the "Spotlights" link on the left navigational area of this page.

Section 4421 of the Balanced Budget Act of 1997 (Public Law 105-33), as amended by section 125 of the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999 (Public Law 106-113), and by section 305 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106-554), authorizes the implementation of a per discharge prospective payment system (PPS), through section 1886(f) of the Social Security Act, for inpatient rehabilitation hospitals and rehabilitation units - referred to as inpatient rehabilitation facilities (IRFs). The IRF PPS will utilize information from a patient assessment instrument (IRF PAI) to classify patients into distinct groups based on clinical characteristics and expected resource needs. Separate payments are calculated for each group, including the application of case and facility level adjustments.
Keeping in Touch
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