

Centers for Medicare & Medicaid Services
Inpatient Rehabilitation Facility Coverage Requirements Conference Call
Moderator: Andrea Yost
November 12, 2009
2:00 p.m. ET

Operator: Welcome to the Inpatient Rehabilitation Facility Coverage Requirement conference call. All lines will remain in a listen-only mode until the question and answer session. Today's conference call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

CMS greatly appreciates that many of you minimize the government's teleconference expense by listening to these calls together in your office using only one line. Today, we would like to obtain an estimate of the number of participants in attendance to better document how many members of the provider community are receiving this valuable information. At this time, please use your telephone keypad and enter the number of participants that are currently listening in.

If you are the only person in the room, enter 1. If there are between two and eight of you listening, enter the corresponding number between 2, and 8. If there are nine or more of you in the room, enter 9.

Thank you. Ms. Yost, you may begin your conference.

Andrea Yost: OK. Thank you, Courtney.

Good afternoon. My name is Andrea Yost, and I will be moderating today's call. Welcome to the Centers for Medicare & Medicaid Services National Provider Training Call on Inpatient Rehab Facility Prospective Payment System Coverage Requirements...a mouthful.

OK. CMS subject matter experts on IRF PPS coverage will be conducting today's presentation. A PowerPoint slide presentation has been developed and was posted to the CMS website. You can access the presentation by visiting our IRF page at www.cms.hhs.gov/InpatientRehabFacPPS, and clicking coverage requirements on the left hand menu.

Our speakers today will be Sheila Lambowitz, who is the Director of the Division of Institutional Post-Acute Care; Dr. Susanne Seagrave, who is the Inpatient Rehab Team Leader in the Division of Institution Post-Acute Care; and Dr. Susan Miller, from our office of Clinical Standards and Quality.

Ms. Lambowitz, I'll turn it over to you, ma'am.

Sheila Lambowitz: Thank you very much.

And I want to thank everybody on the call. We really appreciate your participation. I think all of us have a similar goal. We want to make sure that we understand what the coverage criteria are and that we all perceive in a way that the coverage are – the coverage requirements are implemented appropriately. We've been working on this for several years and we have not been doing it in a vacuum. We have really tried to get input from a variety of stakeholders, some of our own contractors, but also stakeholder groups, associations, and practitioners.

We have had a series of meetings where we have tried to get input from the industry. And I think we have understood some of the concern that we hold the rehab facility responsible for those things that can be controlled. And so you'll see as Susanne goes through the program that we're really looking at factors that apply on admission so that we can make – we can understand how the decision was made whether the patient was a good choice for rehab care or not.

And we are paying less attention to specific services provided during the stay. Now, that doesn't mean that once we look at the preadmission screening, that we don't review the entire case record, because it's not enough to have a perfect preadmission screen. The medical record needs to support that screen and show us that the conditions identified in the preadmission screening actually were applicable throughout the stay.

But Susanne is going to go into that in detail. And what I want to do is just make sure you understand that we are really making every effort to listen to

you and to make sure that the decision making of your practitioners is crucial in determining whether a patient is eligible for IRF care or not.

With that, I'm going to turn it over to Susanne, and she's going to go through this in much more detail, and then we're going to have some case studies for you to think about. Susanne?

Susanne Seagrave: Thank you, Sheila.

If you like, you can follow along with me in the PowerPoint presentation that Andrea mentioned that's on our website. I want to welcome all of you and thank you for participating in today's CMS provider training on the new IRF coverage requirements.

Slide number 2, please. On today's call, I will be giving a brief overview of the new policies. Then Dr. Miller will walk through some case study examples that will help to illustrate how the new policies can be applied. Throughout this presentation, we will highlight some differences between the old and the new policies.

The goal of all this, as Sheila said, is to foster a shared understanding of these policies among all stakeholders. In light of this goal, we gave the same presentation to the Medicare contractor community, which included Fiscal Intermediaries, Medicare Administrative Carriers, Recovery Audit Contractors, and other review entities on November 2nd. We plan to present today for the first hour or so, and then leave the remainder of the time to answer any questions you may have for us.

Slide 3, please. The current policies will remain in effect for all IRF discharges occurring before January 1, 2010, and the new policies will become effective for all IRF discharges occurring on or after January 1, 2010. Of course, this does mean that providers will have to begin applying some of the new admission policies for admissions that occur prior to January 1, 2010, if those admissions will be discharged after January 1st. However, we want to emphasize that these new policies will not apply retroactively to any discharges that occur prior to 1/1/2010.

Next slide please. Why did we update these policies? The time had come to update these policies because they were more than 25 years old. They did not reflect the many changes that had been made in CMS' payment systems over the years. And they no longer reflected the best practices of medicine in IRF today. Most importantly, they were leading to differing interpretations among the IRF community and Medicare's contractors.

Next slide, please. In a nutshell, the purpose of these new policies is to provide clear up-to-date instructions for determining and documenting the medical necessity of IRF admission.

Next slide, please. The new policies were developed by an internal CMS workgroup consisting of general physicians, physiatrists, physical, occupational, and speech therapists, and nurses. In addition, the group enlisted the advice of medical directors from CMS/HHS, several Fiscal Intermediaries, the QICs, and the National Institutes of Health both informally and at a meeting held at CMS on October 31, 2007.

Finally, the workgroup carefully considered feedback from the industry on these policies. Both through comments on the FY2 – fiscal year 2009, and 2010 Proposed Rules, and on the IRF Report to Congress on the IRF classification criteria that was mandated by the Medicare & Medicaid and SCHIP Extension Act of 2007.

Although the IRF Report to Congress was to supposed to focus on the classification criteria, not on the coverage criteria that we're going to be discussing today, the industry submitted lots of comments and suggestions on the coverage criteria during this process.

The goals of the workgroup were to identify the characteristics of patients who require and can most reasonably be expected to benefit from the types of complex rehabilitation therapy services uniquely provided in IRF and to focus on the patient characteristics on admission to the IRF and the services provided during their IRF stay.

Next slide, please. The statement on this slide was one of the principle findings of the workgroup. The point of IRF is to provide intensive

rehabilitation therapy. That is clearly a key element that sets IRFs apart from other settings of care. However, there are a number of other settings that also provide some level of rehabilitative services.

Within these settings, IRFs are the only settings designed to provide the intensive rehabilitation therapy program in an inpatient hospital environment. Further, patients requiring this level of care do so because of the complexity and complex interactions between their nursing, medical management and rehabilitation needs. Another unique feature of IRF is that they provide these services using an interdisciplinary approach to care.

Slide 8, please. From the beginning of this project, we heard stories about patients being transferred too quick and too sick from the Acute Care Hospitals to the IRF before the patients were ready to participate in the rehabilitation therapy programs offered in the IRF. Thus, we want to be very clear that we expect patients to have completed their course of treatment in the referring hospital to the extent that they are able to participate in and benefit from the intensive rehabilitation therapy program in the IRF before they are transferred to the IRF.

We've gotten a number of questions on this, and I want to emphasize that what we mean by this is that the patients must be able to participate in and benefit from the intensive rehabilitation therapy program while the IRF is managing their medical conditions. It does not mean that they have to completely finish their whole course of treatment.

One of the unique features of IRF is that they have the resources available to manage many types of medical complications while patients are participating in the intensive rehabilitation therapy program. But the key is that the patient's condition has to be able to be managed in the setting of the IRF. IRF claims for patients who are admitted before they can participate in the intensive rehabilitation therapy program must be denied.

Slide nine, please. Similarly, the policies are clear that patients who do not require, cannot participate in, or cannot benefit from the intensive rehabilitation therapy program offered in IRF should be referred to another setting, such as a skilled nursing facility for example.

Next slide, please. This brings me to the first common question that we received about the new policies. This question has to do with the interaction between these new IRF coverage requirements and the 60 percent rule used to classify facilities for payment under the IRF Prospective Payment System.

These new coverage policies do not affect a facility's classification as an IRF and are separate from the 60 percent rule policies. Failure to meet these coverage policies will not lead to a facility's payment status as an IRF being revoked. Conversely, the coverage criteria that we are discussing today apply equally to all IRF claims, whether those claims are for conditions on the 60 percent rule list of 13 conditions or not.

Next slide, please. As I indicated on the previous slide, one of the first objectives of the workgroup was to change the focus of IRF medical reviews from what may or may not have happened to the patient's medical condition during their IRF stay, to what the IRF could've reasonably expected to happen given the patient's condition and risk for clinical complications at the time of admission to the IRF.

Thus, the focus of IRF claims review is changed with these new requirements to emphasize what the rehabilitation physician could reasonably have known at the time of the patient's admission to the IRF and what his or her reasoning was when he or she decided that an IRF would be the most appropriate setting for the patient.

For example, suppose that on admission to the IRF, a patient has a risk for a clinical complication that would complicate the patient's participation in the rehabilitation therapy program. This is information that the rehabilitation physician has at the time the patient is admitted, and would be a reason for the IRF stay to be reasonable and necessary even if the patient's clinical complication is well managed by the IRF and does not actually cause any difficulties during the patient's rehabilitation therapy program.

Next slide, please. This slide provides a quick summary of the new policies. The first set of policies outline the required documentation that we expect IRFs to maintain in the IRF medical record for IRF admissions to be

considered reasonable and necessary. These elements must be present for all IRF admissions and must, along with the rest of the IRF medical record, support the admission decision. I emphasize again that the entire medical record must support the IRF admission decision. These documents, along with the entire IRF medical record, must demonstrate that the patient meets all of the required criteria for admission listed in the second half of the slide.

Notice that nowhere on the slide and nowhere in this presentation are we going to talk about whether the patient could have been treated in a skilled nursing facility or another setting of care. Under the new requirements, a patient meeting all of their required criteria for admission to an IRF would be appropriate for IRF care whether or not he or she could have been treated in a skilled nursing facility. I will now discuss these requirements in more detail on the next slide.

Slide 13, please. In these new coverage requirements, we have focused heavily on the preadmission screening, because we believe that a comprehensive preadmission screening process is the key factor in identifying appropriate candidates for IRF care. Whereas, under the previous coverage criteria, patients could be admitted to IRFs for up to a 10-day period to assess whether they were appropriate for IRF care, under these new coverage requirements, the determination of whether the patient is in an appropriate candidate for IRF care or not must be made prior to the patient's admission to the IRF. This requires a more comprehensive preadmission screening process than may have been done before.

To best identify appropriate candidates for IRF care prior to the IRF admission, the preadmission screening must be comprehensive and accurate, timely, and must support the admission decision. To ensure that it is comprehensive and accurate, we require that it be conducted by a licensed or certified clinician or group of clinicians, that it be conducted either in person or through a detailed review of the patient's referring hospital medical record if the patient's IRF stay was preceded by a stay in another hospital, and that it include a detailed and comprehensive review of the patient's condition and medical history.

I note also that we do not consider a form in which the physician merely checks boxes and signs to be comprehensive. What we are looking for is documentation of the physician's decision-making process for each individual patient. In addition, the information provided in the preadmission screening must correspond with the rest of the information in the patient's medical record. Otherwise, it calls into question the accuracy of the preadmission screening.

We are also very concerned that the preadmission screening be current with respect to the admission. To ensure this, we are requiring that the preadmission screening be conducted within the 48 hours immediately preceding the IRF admission. We understand, however, that some IRFs begin the preadmission screening process when the patient is first admitted to the Acute Care Hospital and follow the patient's progress throughout the Acute Care Hospital stay.

Thus, we have put a provision in the regulations to allow for the full preadmission screening to be done more than 48 hours prior to the IRF admission, as long as it includes all of the required elements, and an update is conducted either in person or by telephone to document the patient's medical and functional status within the 48 hours immediately preceding the IRF admission.

Next slide, please. This slide just quickly lists the information that is required to be in the preadmission screening documentation.

Next slide, please. We have received a ton of questions about who may be involved in the preadmission screening process. We have also been asked to what extent non-clinical personnel can be involved in the preadmission screening process. The regulations say that a licensed or certified clinician or group of clinicians must conduct the preadmission screening.

In addition, in the preamble to the regulations, we said that the clinicians conducting the preadmission screening must be appropriately trained and qualified to assess the patient's medical and functional status, assess the risk for clinical and rehabilitation complications, and assess other aspects of the patient's condition both medically and functionally.

Beyond this, we believe that it is the IRF and the rehabilitation physician's responsibility to ensure that the clinicians conducting the screening are appropriately trained and qualified to assess the factors discussed above. We do not believe that it is appropriate for CMS to provide a list of clinicians that do and do not count. Such a list would never be comprehensive and would quickly be out of date.

We stress that the focus of the preadmission screening review is on the quality of the information supplied, and on whether it supports the decision to admit the patient to the IRF, not on the processes including the personnel used to collect and compile the information. Licensed or certified clinicians must conduct the preadmission screening, and administrative personnel can be used to perform administrative tasks.

Next slide, please. Another very common question that we have received involves the timing of the rehabilitation physician's review and concurrence with the preadmission screening. Since the preadmission screening information informs the rehabilitation physician's admission decision, we require that he or she document his or her review and concurrence with the findings and results of the preadmission screening after the screening is completed and prior to the IRF admission.

We believe that this is the only way that we can ensure that the rehabilitation physician has received all of the information he or she needs to make a fully informed admission decision. Again, we've gotten a number of questions about whether this rehabilitation physician can sign something after the admission has occurred and we – and that's not the case. So they have to sign prior to the IRF admission.

Next slide, please, slide 18. This is an important point. The preadmission screening documentation must serve as the primary documentation by the IRF clinical staff of the patient status prior to admission and the specific reasons that led the IRF clinical staff to conclude that the IRF admission would be reasonable and necessary. The real purpose of this whole preadmission screening requirement is to ensure that the IRF clinical staff, in particular the rehabilitation physician, document in the patient's medical record at the IRF,

the specific reasons that they believe that the IRF admission was reasonable and necessary. Medical reviewers will then focus on reviewing this reasoning to ensure that it makes sense.

What is not acceptable is for a checklist form or a one-sentence note from the rehabilitation physician saying something to the effect of Patient A, Ms. Jones, is appropriate for admission to the IRF. The preadmission screening needs to detail the specific reasoning behind this conclusion.

Slide 19, please. Now, that the preadmission screening has been completed, the relocation physician has documented his or her review in concurrence, and the patient has been successfully admitted to the IRF in that order, the next step is for the rehabilitation physician to complete a post-admission physician evaluation of the patient within the first 24 hours of the patient's admission to the IRF. The post-admission physician evaluation should 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.

Next slide, please. This requirement is primarily to ensure that the patient is more or less the same when he or she is admitted to the IRF as the patient who is evaluated in the preadmission screening. In certain cases, a patient could look different after admission, and we want to give the IRF the opportunity to document the differences and the reasons for the differences.

This requirement also serves a couple of other important goals. One is to ensure that the patient is at least seen by a rehabilitation physician in the first 24 hours of admission. And this is one of the reasons why we really do want this to be done by a rehabilitation physician, not a physician extender as some people have asked. We want the patient to be seen by a rehabilitation physician when they first get to the IRF.

We believe that it's important from a quality-of-care standpoint that the IRF patient not go too long without being seen by this physician. Along these lines, it is also important for the patient's expected course of treatment to begin development as early in the IRF stay as possible.

Next slide, please. There are three main elements that must be present in the post-admission physician evaluation. It must identify any relevant changes that may have occurred since the preadmission screening and the reasons for these changes. It must include a documented history and physical exam, and it must include a review of the patient's prior and current medical and functional conditions and co-morbidities.

Many people have been asking the question whether an expanded history and physical exam that includes all of the required elements would satisfy the requirement for the post-admission physician evaluation. And the answer is yes. As long as the history and physical includes all of the required elements and is performed by a rehabilitation physician within 24 hours of the patient's admission to the IRF, it would satisfy the requirement for a post-admission physician evaluation.

Slide 22, please. The next two slides outline the requirements for documenting the patient's admission to the IRF and what should happen if the patient is no longer appropriate for IRF care upon admission. The first step in the process is to ensure that the preadmission screening is complete, accurate, and fully supports the IRF admission decision. If not, the IRF admission is not reasonable and necessary.

However, if the answer to this question is yes, then the next step is to determine whether there are any relevant changes in the patient's condition between the preadmission screening and the post-admission physician review. If there are none, then the rehabilitation physician must document the absence of change; include the documented history and physical exam and the other required information.

However, if there are relevant changes to the patient's condition, the next question is even with these changes, is the patient still expected to participate in and benefit from the intensive rehabilitation therapy program provided in the IRF. If the answer is yes, then the rehabilitation physician simply needs to document the relevant changes and the reasons for these changes, include the documented history and physical exam and the other required information and the IRF stay can proceed.

However, if the answer is that the patient's change in condition no longer allows the patient to participate in and benefit from the intensive rehabilitation therapy program in the IRF, then we move to the next slide, slide 23.

Under these conditions, the IRF must immediately begin the processes of discharging the patient from the IRF. Ideally, this will take no more than three consecutive calendar days. However, even if the process takes longer than three days, the IRF will still only be eligible to receive the payment for IRF stays of three days or less.

We note that this should be a very rare occurrence. This scenario will only occur when the comprehensive preadmission screening indicated that the patient was fully expected to – was reasonably expected to participate in and benefit from the intensive rehabilitation therapy program in the IRF but something has changed that makes this no longer true. Instead of denying the claim, we are authorizing the IRF to receive the IRF short-stay payments. We will monitor this policy closely to ensure that it is not being used excessively.

Slide 24, please. Assuming that the IRF stay continues, the next requirement is for the rehabilitation physician to develop an individualized overall plan of care for the patient's care in the IRF. The main purpose of this requirement is to promote the best possible outcomes for the patient.

Slide 25, please. The key elements of the overall plan of care are the following. It must be individualized to the unique care needs of the patient. We have often been asked if we could provide a template for the overall plan of care. This is impossible, because each overall plan of care will, by definition, be different to reflect the individual needs of each patient.

It is typically based on information from the preadmission screen and the post-admission physician evaluation and information garnered from therapy assessments. This information must be synthesized by a rehabilitation physician and the documentation must be completed within the first four days of the IRF admission.

Slide 26, please. This slide lists the information that is required to be included in the overall plan of care.

Next slide, please. One question we have repeatedly been asked is, whether the first interdisciplinary team meeting has to occur within the first four days to establish the overall plan of care. No. While it might be good practice in general to hold the interdisciplinary team meeting in order to get the whole team's input into the overall plan of care, this is not required.

I want to note, too. There was some confusion in the questions about whether the interdisciplinary team had to be involved in the post-admission physician evaluation. They do not. That is the responsibility of the rehabilitation physician; as well as the overall plan of care is also the responsibility of the rehabilitation physician. However, the interdisciplinary team meetings, obviously, have to involve the entire team.

The overall plan of care, as I said, is the responsibility of the rehabilitation physician. The only requirement regarding the timing of the first interdisciplinary team meeting is that it occur weekly during the IRF stay, which would mean that the first one would need to occur sometime within the first seven days. This is a good opportunity to clarify CMS' definition of a week. Throughout these requirements, the definition of a week is a seven-consecutive-day period starting with the day of admission. The day of admission does count as day one.

Next slide, please, slide 28. The fourth documentation requirement is the admission orders. This requirement is not substantively different from what was in the previous rule. We just revised the wording somewhat to make it more clear when the orders must be generated, and that the orders must be retained in the medical record at the IRF. I note too that we just say that a physician must generate these orders, not a rehabilitation physician.

Next slide, please, slide 29. Under the new documentation requirement, a copy of the patient's IRF Patient Assessment Instrument form must be retained in the patient's medical record at the IRF. This must be the same IRF Patient Assessment Instrument form that was submitted to Medicare. In addition, the information on the IRF Patient Assessment Instrument must correspond with the information in the patient's IRF medical record.

Slide 30, please. This slide gives an overview of the five new criteria for an IRF claim to be considered reasonable and necessary. I note that there must be a reasonable expectation at the time of admission that a patient meets all of these criteria for the IRF claim to be considered reasonable and necessary. In the next slides, I will go into more detail about each of these criteria.

Slide 31, please. The first criteria is that the patient must require multiple therapy disciplines. Patients who only require treatment by one therapy discipline do not need to be cared for in an IRF. They can receive rehabilitation therapy services in another setting of care. This is also a good place to define the therapies that must be provided in an IRF; the four therapies that must be provided in an IRF are physical, occupational, speech-language pathology, and orthotics/prosthetics.

Though psychology and neuro-psychology must be provided as well, they are separately billable in general under Medicare Part B, and are thus not part of the required bundle of therapies provided within the IRF prospective payment.

Similarly, though other types of treatments such as recreational therapy, music therapy, and respiratory therapy are Medicare-covered services in IRFs if the medical necessity is well documented by the rehabilitation physician and as ordered by the rehabilitation physician as part of the patient's overall plan of care, we do not believe that these treatments should replace the core therapies, and therefore, we do not allow them to count towards demonstrating the required intensity of therapy in IRFs.

Slide 32, please. The regulations require that one of the therapy disciplines be either physical or occupational therapy. So I note that in most cases, both of these will be required.

Next slide, please. The second criterion is that there must be a reasonable expectation that the patient, on admission, requires the intensive rehabilitation therapy program provided in IRF. I note that we added in the reasonable expectation language to account for the fact that we realize that no judgment, even the highly trained and experienced judgment of a rehabilitation physician, can be a hundred percent accurate all of the time.

However, we expect that in nearly all cases of patients admitted to IRFs, the rehabilitation physician's judgment will be accurate. Although the required level of intensity has typically been demonstrated in IRFs by the provision of at least three hours per day of intensive rehabilitation therapy services at least five days per week, this is not a rule of thumb. And the intensity of therapy requirement could be demonstrated in certain well-documented cases by the provision of at least 15 hours of therapy per week.

Again, I emphasize that a week is a seven-consecutive-day period starting with the day of admission. Note that we provide a brief exceptions policy to this intensive therapy requirement which I will discuss later.

Slide 34, please. Briefly, I want to point out that the new policies require the initiation of therapy to begin no later than 36 hours from midnight of the day of the admission to the IRF. I note because there has been some confusion that we still do count the day of admission as day one for the purposes of providing therapy. However, if the IRF chooses, they can wait until no later than 36 hours from midnight of the day of admission. Ideally, the therapy would be started sooner, however.

The purpose of this requirement is to ensure that patients do not linger for days after admission, say over a weekend or a holiday, without receiving the crucial initial therapy treatment that can often lead to improved functional outcomes in the long run. We have received a number of questions and want to be clear that therapy evaluations may constitute the initiation of therapy services, and that they also count for the purposes of documenting the required intensity of therapy provided in IRF.

Slide 35, please. Although CMS has not yet established specific standards for the provision of group or concurrent therapies in IRFs, we believe that the standard of care for patients, for IRF patients, is individualized, one-on-one therapy. We do not consider concurrent therapy as the same as individualized one-on-one therapy. Group therapies and concurrent therapies should serve as an adjunct to individual therapies in IRFs, which does mean that they should generally be provided above and beyond the requirements for one-on-one therapy.

However, all that we are requiring at this point is that providers justify their use of group therapies in a particular case in the patient's medical record at the IRF. Provision of group therapies will not be a reason for denial of a claim; although, we will closely monitor IRFs that are found to make excessive use of group therapies to the exclusion of individual therapies.

Slide 36, please. As I have said before, we have implemented a brief exceptions policy to the intensive rehabilitation therapy program in IRFs. That is, contractors are authorized to grant brief exceptions, not to exceed three consecutive days, to the intensity of therapy requirement due to unexpected clinical events that could limit the patient's ability to participate in the therapy.

The reasons for these brief interruptions in the intensive rehabilitation therapy program must be well-documented in the patient's medical record at the IRF. Here we provide some examples of unexpected clinical events that could warrant a brief interruption in the patient's therapy program. This is not meant to be an exhaustive list of the conditions that could warrant such a brief interruption.

Slide 37, please. I reiterate that the reasons for the brief interruption in the therapy program must be well-documented in the patient's medical record at the IRF. Again, we will monitor this policy closely to ensure that it is not being used inappropriately. For example, we would not expect to see the situation occurring every weekend because of staffing constraints on the weekend. This policy must only be used for unexpected clinical events that may temporarily limit the patient's ability to participate in therapy.

Slide 38, please. Criterion number three requires that the patient's condition be such that the patient can actively participate in and benefit from the intensive therapy program provided in the IRF. I stress that that should be the case at the time of admission.

This gets back to my original point at the beginning of this talk, that the patient's condition when he or she is transferred from the referring hospital to the IRF should not be such that the patient needs one or two or three or more days in the IRF before he or she can participate in the therapy program. The

patient must be expected to be able to participate in the intensive therapy program on day one of the IRF stay.

Slide 39, please. By “benefit from the intensive therapy program”, we mean that the patient must be expected to make measurable practical improvement in his or her functional condition, and that such progress must be expected to be accomplished within a predetermined and reasonable period of time.

Although measurable improvement is not necessarily a quantifiable concept, it is one that it is well understood within the physiatrists and the rehabilitation communities.

Slide 40, please. Generally, the goal of IRF treatment should be the patient's safe return to the home or community-based environment, though each and every IRF patient may not be expected to achieve this goal. IRF patients do not have to be expected to achieve complete independence in the domain of self-care. Though the IRF medical record must demonstrate that the patient is making functional improvements that are ongoing and sustainable, as well as of practical value measured against his or her condition at the start of treatment. Obviously, this will be subjective. However, it should be readily apparent to the experienced rehabilitation physician when this is not the case.

Next slide, please, slide 41. The fourth criterion is that the patient must require the level of sufficient supervision provided in an IRF. Under the new regulations, this is demonstrated by the patient's need for face-to-face visits by a rehabilitation physician or other licensed treating physician with specialized training and experience in rehabilitation at least three days per week throughout the IRF stay.

We have been asked whether a physician extender could conduct these visits, and the answer is no. They must be conducted by a licensed physician. Physician extenders generally work under the direction of a physician and can perform certain tasks as delegated by a physician, but the level of assessment we are expecting from the three physician visits per week requires the judgment of a licensed physician.

Slide 42, please. We have also been asked a lot why we did not require these visits at least five days per week or even every day, given that the IRFs

provide a hospital level of care. The three days per week is a minimum. IRFs are certainly welcome to provide more than this. However, this requirement is specifically to ensure that IRF patients receive more comprehensive assessments of their functional goals and progress in light of their medical conditions by a rehabilitation physician with the necessary training and experience to make these assessments.

Slide 43, please. The fifth and final criterion is that the complexity of patients' nursing, medical management, and rehabilitation needs must require an inpatient stay in an interdisciplinary team approach to care. That is one of the unique features of IRFs.

Slide 44, please. The purpose of the inter-disciplinary team in IRFs is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals.

Slide 45. In light of this purpose, the interdisciplinary team meetings must be led by a rehabilitation physician with specialized training experience and must be attended by 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 every therapy discipline involved in treating the patient. The participants must all have current knowledge of the patient.

We have been asked whether physician extenders can lead the team meetings, whether licensed practical nurses or others could substitute for the registered nurse at the team meetings, and whether one therapy representative such as the physical therapist, for example, could bring notes from all of the other therapy disciplines to the meetings so that the other therapy disciplines do not actually have to attend. The answer to all of these questions is no. The required participants must be at every team meeting. If the registered nurse is absent due to illness on the day of the team meeting, he or she must send another registered nurse with knowledge of the patient to take his or her place.

Next slide, please. This slide indicates the points that must be discussed during the weekly team meetings. I emphasize again that the change from the previous policy was previously we required the team meetings every two weeks. Now, they're required every week. This is due to the shorter lengths

of stay in IRFs today, with the average being about 13 days, and the average for some orthopedic patients being only eight days.

Slide 47, please. This slide provides some references for finding the new policies in both the regulations and the manual. All of this information is located on our IRF PPS website. We have set up a special link called "coverage requirements" to house the information specifically about these new policies. I also want to draw your attention to our contact information on the second to last slide of this presentation. You can feel free to contact us if you continue to have questions about these new policies.

Now, I will turn the presentation over to my colleague, Dr. Susan Miller, from CMS' Office of Clinical Standards and Quality. She will walk through some case study examples of how the new policies will be applied to specific cases. Prior to working at CMS, Dr. Miller was a practicing psychiatrist for over 25 years; much of it spent performing evaluations of acute care patients for IRF.

Dr. Miller.

Susan Miller: Thank you, Dr. Seagrave.

As you all have just heard, previously the regulations for coverage and non-coverage of IRF admissions depended on a retrospective look back to see if the services could have been provided at a lower level of service. Questions that were frequently asked included among others – did the patient need a doctor to frequently assess or intervene in a patient's care? And did the patient need a nurse with specialized rehabilitation training or experience?

The current regulations do not allow for this. Instead, assuming all documentation requirements are met at the time of admission to an IRF, the patient's need – must need – as you have just heard – multiple therapies, one of which must be PT or OT; an interdisciplinary approach; medical supervision as was just defined for you; and the patient's potential must be such that they can participate in and benefit from intensive therapy, and specifically that they are medically appropriate to do so.

I'm going to review three cases for you very briefly comparing the way that these cases would have been looked at under the old regulations and now the new. Case one is that of an 80-year-old woman who underwent a bilateral total knee replacement. Post operatively, she experienced a myocardial infarction complicated with congestive heart failure.

After a 10-day difficult course, her medical condition began to stabilize though her medications were still changing at the end of her acute care stay. She was able to participate in a few days of PT and OT, limited to one hour per day due to staffing concerns at the acute care facility. She appeared motivated to improve.

At the time of discharge, she was max assist in all ADLs. She was able to participate in transfers at the max assist level and ambulate a few steps to a chair from her bed with max assistance. She was cleared by her cardiologist and her orthopedist to perform ambulation and ADLs at a weight bearing as tolerated level.

Previously, this patient lived with her husband who was reasonably healthy in a two-story dwelling. Her goal was to return to home independently in ADLs and ambulation, and she accomplished this without medical incident during her rehabilitation stay.

Based on the old regulations, this patient would not have been cleared for IRF level rehab, because ,at least, she would not have been thought to require 24 hours specialized rehab nursing care; and because on the look back, if she had done well medically during her rehab stay, she would not have been thought to need a physician's supervision.

However, under the current regulations, this patient is a candidate for IRF rehab, because at the time of admission, this patient does need multiple therapies. And it is believed that she can participate in and benefit from, and that she needs an intensive level of therapy. She requires intensive therapy as well as can participate in it and benefit from it.

The intensive nature of the therapy is referring to the fact that she needs complicated therapy compressed into a short period of time for three hours a

day. Her intensive nature of therapy comes from the need for blood pressure and heart rate monitoring by therapists before, during and after therapies; from EKG monitoring if it is available; and the potential for frequent consultation with a physician regarding the monitoring of her vital signs as they relate to her performance as well as the change of pace in her performance, meaning how long it takes her to progress from one level of activities to the next level as described, for example, by net levels.

The other question is, "Does she need doctor supervision?" Yes, for the reasons that we have just stated above. Does she need and can she benefit from an interdisciplinary team approach? Yes.

Case two refers to a 72-year-old male, previously living independently in a two-story home with his family who was admitted to an acute care facility, status post-CVA with left hemiparesis and cognitive impairments. The head CT scan demonstrated a right PCA infarct affecting the occipital lobe.

At the time of admission, that facility reported that the patient was moderate assist for bed mobility, moderate assist for transfers, dependent for ambulation and mid-mod assist for ADLs. Communication skills were reported at a supervisory level. The patient further exhibited dysphasia. He also demonstrated agitation and confusion especially at night.

The patient's co-morbidities included arterial fib. The patient was on Lovenox and Coumadin with INR values that were not yet therapeutic. Discharge disposition was expected to be home under supervision of the family, which was accomplished again without medical incident.

Under the previous system, this patient was denied the coverage for an IRF admission, because the patient was judged to be medically stable. And two days after admission to the IRF he was ambulating a 110 feet with minimal assistance. It was also stated that he followed two-step commands inconsistently and was intermittently agitated and could not participate in nor benefit from the IRF intensive level of therapy.

Under the current regulation, I believe that this patient represents the exact type of rehab patients that IRFs are created for. He requires multiple

therapies. He can benefit from and participate in an intensive level of therapy. I feel like I'm preaching to the choir, but it must be said that he can follow two-step commands inconsistently and that there is agitation. And those factors are of no concern, because that is what a brain injured patient frequently presents as; and that is exactly what this patient needs rehabilitation for.

Furthermore, does this patient need physician supervision? Yes, he does. He will require anticoagulation changes and perhaps medication for his agitation and confusion, hopefully, without the need for physical restraints being added to his program. And does he, again, need and can he benefit from an interdisciplinary team approach? Yes. In my experience, most patients that I have described of this type do get better.

Case three is that of an 82-year-old woman working as a librarian 20 hours per week, living independently with her husband in an elevator accessible condominium. The woman experienced two witnessed falls in the week prior to her acute care facility admission. These falls were thought to be secondary to environmental obstacles. However, on the day admission, increasing unsteadiness was noted along with a third fall, and the patient experienced an episode of bowel incontinence.

The workup performed in the acute care facility indicated a spinal cord injury infarct of the high thoracic area, probably T2. No MRI findings were noted, but the patient exhibited a distinct sensory loss in the area described. While in the acute care facility, the patient exhibited no incontinence or retention for that matter of bowel and bladder. Her mild hypertension was well controlled. Her heart rate at times did drop between 40, and 50, but a call to her cardiologist confirmed that this was a known finding, and in fact upon previous stress testing, the patient had demonstrated normal cardiovascular responses to exercise.

While in the acute care facility, the patient's transfers and gaits improved to minimal assistance, so her balance did remain poor. Against medical advice, the patient cruised in her room independently. A physical therapy note in the chart on the day prior to discharge noted one session with the use of a cane

which proved successful, with the patient's gait being assessed at the end of that session at a contact guard to minimal assistance level.

Under previous regulations, I believe that this patient would not have gone to an IRF. And under the new regulation, I also believe that this patient is not an IRF candidate. Does this patient need multiple therapies? Yes. She can benefit from PT and OT. However, does she need and can she participate in and benefit from an intensive level of therapy? It is my opinion that though the patient can definitely benefit from therapy, the question is really does she need intensive IRF level therapy. And in my opinion, that answer is no.

In one session, this patient was noted to improve her gait with a cane. It would be a reasonable assumption to predict that with another session or two, the patient would be independent in the use of a cane. In fact, if she had stayed in the acute care facility for one or two more days and had received additional physical therapy there, she probably could have gone home with either home or outpatient therapy. If this were not possible, then, her therapy could be delivered in a skilled nursing facility which would then also incorporate the patient's ADLs into her therapy training.

Does this patient need physician supervision? No. There are no medical conditions that need close follow-up to advance her level of independence.

And does this patient need the kind of interdisciplinary team approach that can be provided at an IRF? Anybody can improve with such interdisciplinary intervention, but the complexity of her case just does not warrant it.

I hope then these examples will help provide you with some indication of how the regulations should be applied.

Andrea Yost: Thank you very, very much. I think now we are going to open the call up for questions. Did you want to answer any of the questions you had already received or just get right directly...?

Sheila Lambowitz: No.

Andrea Yost: All right, OK. Operator would you – can you please open up the phone lines?

- Operator: All right, we will now open the lines for a question and answer session.
- To ask a question, press star followed by the number 1, on your touch tone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking a question, and pick up your handset before asking your question to assure clarity. Please note that your line will remain open during the time you are asking your question. So, anything you say or any background noise will be heard in the conference.
- Your first question comes from the line of Judy Ethic. Your line is open.
- Judy Ethic: Thank you. My name is Judy Ethic. I'm calling from UCH Rehab in Tampa. On the slide about the admissions orders, the time of the admission a physician must generate admission orders for the patient's care. Our physician group does have the physician extenders that also take call. Would it be all right for the physician extenders to give the admission orders for this patient?
- Susan Miller: As long – it appears that the requirement is that the admission orders be prepared by a physician, and so that is what must happen.
- Judy Ethic: OK, thank you.
- Operator: Your next question comes from the line of Diana Smith. Your line is open.
- Diana Smith: Diana Smith, North Hills Hospital Rehab.
- We were wondering, since the prosthetist is considered part of the team and was listed, are you saying that they too need to attend team conference?
- Susanne Seagrave: Yes.
- Susan Miller: Yes. If they are treating a patient, yes.
- Diana Smith: Active treatment or we have prosthetist, say, who fits – and fits a patient for a stump extender or begins prosthetic management for amputation. They need to be at team conference?
- Susan Miller: They are actively treating that patient? Yes.

Diana Smith: All right, thank you.

Operator: Your next question comes from the line of Susan Glenn. Your line is open.

Susan Glenn: My question is on, from slide 8, talking about if a patient is completing their course of treatment in a referring hospital. What about a patient, say, a cancer patient who is still undergoing chemo or radiation but is still able to participate in therapy? Is that patient that's appropriate for admission for an inpatient rehab setting?

Susanne Seagrave: As we said, if the patient can fully participate in the intensive rehabilitation therapy program, if they require that level of intense therapy- can participate in it and can benefit from it at the time of admission, then yes.

Andrea Yost: Is there a follow-up to that question?

Susan Glenn: No, that was all. Thank you very much.

Andrea Yost: Thank you.

Operator: Your next question comes from the line of (inaudible). Your line is open.

Andrea Yost: Hello, are you there? Operator, there doesn't seem to be a caller there.

Operator: OK. Your next question comes from the line of Rachelle Smart. Your line is open.

Randy Roy: Oh, hi. This is Dr. Randy Roy, from Louisiana. I was wondering with regards to the post-admission screening. I'm in a facility that is in a rural location. I'm the only rehabilitation physician at that facility, and I'm very involved with every preadmission screening.

Once they're admitted to the hospital, the 24-hour post-admission rule would be rather onerous for a facility that keeps a seven-day admission running. So, we would have to close admissions if that requirement is in place. I do have a nurse practitioner. But according to the rules stated, she would not be allowed to be involved in the post-admission screening process. So that means that we

do have to close admissions when I am not available for that day. When I'm on vacation, we have locum tenens service, but when I'm not here for my day off per week that could potentially be a problem that would close admissions.

Susan Miller: Can you hold one second? We're conferring here. Yes. The post-admission evaluation must be performed by a physician and not an extender.

Randy Roy: So we'll have to close admissions on those days that I'm off?

Susan Miller: If that is your practice, then that is your decision.

Randy Roy: OK.

Susan Miller: I think perhaps the question will also come up later. Can a resident physician perform the post-admission evaluation? And the answer to that is that the attending physician must perform that evaluation.

Randy Roy: That will be very onerous for facilities that are in rural locations. I would just like to make that noted.

Andrea Yost: We will take that under advisement, and we'll – if there's any other further follow-up, we'll post it to the website.

Randy Roy: Thank you.

Andrea Yost: Thank you. Operator, can we go to the next call please?

Operator: The next question comes from the line of Robert Wiese. Your line is open.

Robert Wiese: Yes, this is Robert Wiese in California. I'm a patient advocate for lymphedema patients. I have two questions. One concerns the qualifications of the "licensed or certified therapist" which is referred to on slide 16, in conjunction with the preadmission screening, and on slide 45, with respect to the team participants. Medicare does not have any requirements on the physical therapist who or the training of the physical therapist to treat lymphedema patients.

This is a thing having to do with, well; if the physical therapist is licensed then they are allowed to bill for and treat lymphedema patients with no specific specialist training necessary. So my first question has to do with what requirements on the qualification for specific conditions are there for admission and treatment in an IRF.

My second question has to do with bandaging and fitting of garments which are part of the standard treatment in the intensive phase for lymphedema treatment. Who does the bandaging? And again, are there any specific training requirements for the, either the physical therapist or the prosthetist who applies the bandages and who does the fitting for the garment?

Is there any skilled care requirement? Because I know that Medicare does not consider bandaging for lymphedema treatment as a skilled – procedure a skilled issue -I firmly disagree with that, because it does requires special training, but the Medicare requirements claim that the bandaging done in lymphedema treatment are not skilled procedures. So how is that...

Sheila Lambowitz: I thank you for bringing that to our attention. I know this is a complicated issue. I'm going to turn this over to Dr. Miller.

Susan Miller: Yes. Mr. Wiese, the skills and qualifications of the therapist must be examined by the IRF and it is the IRFs responsibility to provide appropriate treatment and the personnel who will provide that treatment. The other question just based on the topic is that those patients who require this therapy or the lymphedema therapy must meet all the other requirements for an IRF admission in order to be admitted for that purpose.

Andrea Yost: The requirements that you're asking about specific treatments and modalities and stuff is something that we would have to address on a different call. That's not part of this call that we're actually taking calls on right now.

Susan Miller: And Mr. Wiese, as I know that you are aware of the CMS MEDCAC on lymphedema is next week on Wednesday.

Robert Wiese: Yes, I had my five minutes-of-fame schedule.

Sheila Lambowitz: Yes, I know that you do.

Susan Miller: All right. Well, thank you very much for bringing it up.

Robert Wiese: Thank you.

Andrea Yost: Operator, let's go to the next call please.

Operator: Your next question comes from the line of Mark Rosell. Your line is open.

Andrea Yost: Hello, are you there?

Mary Catner: This is Mary Catner, I'll be speaking instead of Mark Rosell, from Clear Lake Regional Medical Center. I have a question about the weekly team conferences. If a patient comes – if a doctor has a team conference on Tuesday morning, and then a patient, his patient is admitted Tuesday afternoon after he's already left the building, we must do a team conference on him. I want to make sure this is correct. It would have to be before the following Tuesday or could we...? Because if you count the day the patient comes as day one, then day eight would be his next team conference, on the following Tuesday.

Would that – could we still do the team conference on that following Tuesday or would it have to be on – by Monday?

Susan Miller: The team conference must be done within the week, and so that would make it on Monday.

Mary Catner: OK. All right, thank you.

Andrea Yost: Thank you. You're welcome.

Operator: Your next question comes from the line of Mary Allen Davis. Your line is open.

Nancy Shanahan: This is Dr. Nancy Shanahan, at Saint Mary Rehabilitation in Langhorne, Pennsylvania. I'm going back to the team conferences. If the patient is receiving recreational therapy, which I understand can be paid for if the

physician orders it – does the recreational therapists and does the psychologists have to attend team conference?

Susanne Seagrave: If, if they are treating, actively treating the patient, then yes.

Nancy Shanahan: OK, thank you.

Andrea Yost: Thank you.

Operator: Your next question comes from the line of Frank Highland. Your line is open.

Pat Wilkes: Hi, this is Pat Wilkes, calling from the Good Shepherd Rehab Hospital in Allentown, Pennsylvania. My question is related to the preadmission screening.

In slide 15, if all the information that is required in slide 15 is clearly documented on the screening tool, when the physician reviews that documentation, is it necessary for the physician to actually write an explanation of why they agree or can they just sign? And if they can just sign, can they sign electronically?

Susan Miller: The physician must write some justification for the admission using the information that has been gathered. Is that clear enough? The preadmission evaluation can be thought of as more of a gathering of information for the physician to use to make up his or her mind as to whether or not the patient is appropriate for an IRF admission. Therefore, the physician must make his or her reasoning clear from the information that is above on the form or on a different form or whatever. They also must sign and date and time the rationale for the admission so that it is known that it occurred prior to the patient's actual physical admission.

Susanne Seagrave: Yeah. One thing I wanted to add to what Dr. Miller said, we have discussed that an e-mail from the doctors specifying what Dr. Miller just indicated would be sufficient.

Andrea Yost: Do you have a follow up to that? OK. Operator, we can go to the next call.

Operator: OK. Your next question comes from the line of Robert Romero. Your line is open.

Robert Romero: Hello, yes. My question is in reference to the recreation therapist and the use of CRT times and how that is documented and how that affects the total usage of hours in the treatment day.

Susanne Seagrave: Can you explain what CRT time is, please?

Robert Romero: Community Reintegration. Like, our rehab facility takes the patients out to, say, the local stores like Wal-Mart or they'll go to museums to get the patients interactive in the community again, and assess curb management, obstacles such as the aisles in stores and those sort of things. And all of our staff go with them.

Susanne Seagrave: Well, I'm not sure what your question is, but we've been specific that that type of therapy does not count towards the demonstrating the required intensity of therapy requirement.

Andrea Yost: May we go offline for just one minute, please? We'll be right back.

Susanne Seagrave: Hold on, one second.

Robert Romero: OK.

Susanne Seagrave: I want to clarify my earlier statement. You said that it was conducted by a recreational therapist as part of recreational therapy services, and that's what I understood your question to be. And we've been very clear that that would not count in the required documentation of intensity of therapy. However, if, if some of these activities were conducted by physical or and/or occupational therapists and they were specifically physical or occupational therapy, you know, requirement then that would count towards the required services.

Robert Romero: OK. And then back to the team conference, one more part of the question. If our time clock begins on the day of the admission at midnight, will that, say, I had a patient admitted today right now and the time clock begins at midnight tonight, will not the seventh day be next Thursday?

Susanne Seagrave: No. The day of admission is day one.

Robert Romero: OK.

Susan Miller: The patient must begin to receive their physical therapy within 36 hours...

Robert Romero: Correct.

Susan Miller: Of the midnight of the day of admission. The purpose of that is to give the IRF and the IRF staff an opportunity to work up any unanticipated medical conditions that might have occurred since the preadmission screen and the admission or, perhaps, to check on spinal stability after an ambulance ride or things of that nature.

Robert Romero: All right. Thank you very much.

Andrea Yost: Thank you.

Operator: Your next question comes from the line of Amy Cruise. Your line is open.

David Lacey: Hi, this David Lacey. I'm the new Medical Director at the Wake Forest University for the Rehab Unit. I actually have two questions, both really just kind of tie into documentation. First question is, I'd like some clarification about the plan of care in the post-admission physician evaluation. Can the plan of care be included in that post-admission physician evaluation or must it be a separate document? And then after you answer that, I'll ask the second question.

Susanne Seagrave: I think it's OK for the post-admission physician evaluation and the overall plan of care to be, as you say, the same document. I would, just for the convenience of reviewers just because this helps you really in the long run, if you, you know, make sure and indicate somehow in the record that they're both included so that the physician reviewer – or the reviewer conducting the medical review knows what they're looking at. That's all.

Susan Miller: I would also, just a caution again, to make certain that the medical reviewer is aware that the summary statement that is often at the end of some history and physicals is – for hypertension, we're going to give the patient this medication

or that medication or, you know, for whatever the conditions are. And certainly, the overall plan of care is expected to be much more detailed than that and very much tailored to the patient's rehabilitation needs. So, just make certain that that is well documented so that a reviewer would be able to pick out those portions of your – in your post-admission evaluation.

David Lacey: But I'm assuming, and maybe incorrectly, that the H&P and the post-admission physician evaluation have to be two separate things or can they be a single document.

Susanne Seagrave: No, as I said in my presentation, we've been asked the question a number of times whether physicians can expand their H&P to include some of the additional elements that we're asking for in the post-admission physician evaluation and then essentially use it for that. And I said in my presentation that, yes, an expanded H&P that includes all the required elements and that is conducted by rehabilitation physician within 24 hours immediately following admission would be acceptable.

David Lacey: OK. And then the second question I have is, if a physician extender and the physician do the evaluation together and discuss the patient in detail, can the physician extender do the documentation as long as it is very clear in the documentation that the attending physician did indeed see the patient with the physician extender and formulated the plan of care or...

Susan Miller: It is expected that the physician will be the person who documents.

David Lacey: So the physicians actually have to do the actual documentation?

Susan Miller: Yes.

David Lacey: And does that also the physician extender, I'm assuming, that applies only to nurse practitioners and PAs. If you're working with a fellow or a resident can they do the documentation as long as it is very clear that we work together?

Susan Miller: All of the attending physician education rules would stand, which means that the physician would have to be there as the resident performed the exam or would have to repeat those portions of the exam that were not seen.

David Lacey: Excellent. That answers my questions. Thank you.

Operator: Your next question comes from the line of Joe Leone. Your line is open.

Dr. Craig Dove: All right, Dr. Craig Dove, from Saint Luke's Hospital, Cedar Rapids, Iowa. A couple of questions, number one, our Rehab Unit is also in a large acute care hospital. Oftentimes, we'll see patients for evaluation and they're in the acute part of the hospital, and we'll do a formal consultation which is effectively our H&P for our hospital here.

Under the new guidelines, will that still suffice as an the H&P or do we have to repeat the whole thing even though they may come up to us that same day when we do that consultation?

Susan Miller: Because not every hospital works as you work, there will need to be a separate H&P for the post-admission evaluation. How long it is and how detailed it is, is up to you. If you have, let's say, in the morning done a prior H&P but there will have to be two documents because there can't be two different rules for hospitals which have different processes.

Dr. Craig Dove: OK. My next question, the preadmission screening documentation, is that considered part of the hospital medical record? Because this is being generated before we even have a patient have seen the patient, oftentimes, they're coming from other facilities and we've never seen the patient before.

Susan Miller: Yes, but they must be reviewed in some manner before they come to your facility so it would be your document.

Susanne Seagrave: They must either, as we said in the regulation; they must either be assessed in person or through a careful review of the referring hospital's medical records. That's what we say. It can either – the assessment can either be done in person or by telephone through a transmission of the referring hospital medical records, and a careful review of those medical records. So...

Susan Miller: So it is your document.

Dr. Craig Dove: I understand that, but we're still – my question is – we're generating a document before we've even admitted a patient. Where does that document

be stored? Because it's, technically, it's, you know, that patient isn't even being admitted yet.

Susan Miller: If that is your process, if the patient is admitted, however, that document would then be stored in the patient's medical record. Should you decide not to admit the patient then you may store it as you see fit. But if that patient is admitted then it becomes a part of their medical record at the IRF.

Dr. Craig Dove: OK. And then, one last question. I just wanted to clarify this. For the therapies, and needing at least of the two therapies for a meeting Comprehensive Inpatient Rehab Criteria, it used to be – PT had to be one of them and then either OT or speech. But if I'm hearing you right – for example, we have a brain injured patient that's cognitively impaired, but it reaches the point in a day or two they're independent with mobility, don't really need PT, but they will still need cognitive remediation like OT and speech, would that still qualify for inpatient rehab?

Susanne Seagrave: What the regulations say is that they must require multiple therapy disciplines, at least one of which must be physical or occupational therapy. So it's not true that they have to require both physical and occupational therapy. It's at least one of them must be physical or occupational therapy.

Dr. Craig Dove: OK. Thank you.

Operator: Your next question comes from the line of Aida Johnson. Your line is open.

Dr. Byers: Thank you. I'm Dr. Byers, Medford, Oregon.

I have a couple of comments before my question. One is the amount of the documentation that is now being required by the physicians. I want to join my vote with the previous physician, and say that it's almost untenable as a burden, so please take that back to whoever might think about it.

The other one is, I heard you say that a physician extender could not do the History and Physical. And I believe when I reviewed the Federal Register statements recently, they said that the H&P could but the preadmission

information – screen, and the Post-Admission Evaluation had to be done by the physician specialist. So, just that comment.

My question is this, on slide 25, could you please help me with what you mean by synthesized? The overall plan of care must be synthesized by a rehabilitation physician.

Susan Miller: By that, we mean that it is accepted practice to have a physical therapy plan of care, an occupational therapy plan of care, et cetera. We are not looking for those individual plans of care. We are looking for a physician to state basically the goals of admission, how they will be accomplished, the timeframe in which they will be accomplished. It is not necessary that the physician plan or document his or her plan of care including every single line of the PT, OT speech, et cetera, plans of care.

Susanne Seagrave: Right. I want to add all the requirements for the overall plan of care are on slide 26, so you can review those. Those are what need to be in the overall plan of care.

Sheila Lambowitz: And we will take your comments under consideration. I appreciate your letting us know your concerns.

Dr. Byers: Thank you.

Operator: Your next question comes from the line of Barbara Lowitz. Your line is open.

Barbara Lowitz: Thank you. This is Barbara Lowitz, with Rehab Institute of Chicago. I have two questions. The first one is rather quick. We were just wondering why the Medicare Benefit Policy Manual implementation date is January 4th?

Susanne Seagrave: Well, that's a technicality because I think that's a Monday or something. But the effective date on the policy, if you see, is January 1st, 2010. So, you can kind of ignore the January 4th date.

Barbara Lowitz: OK. Thank you. And the second question is in regards to Thursday admissions in the individualized overall plan of care. We understand that it's the sole responsibility of the attending physician to create that document. But for Thursday admission patients – on Friday and Saturday, you have the

evaluations being completed, and on Sunday, there's typically a coverage physician who would not have the same intricate knowledge of the patients. Would it be acceptable to have the attending physician to complete that individualized overall plan of care on a Monday, which would be day five?

Susan Miller: The individualized overall plan of care must be completed in four days. The process...

Barbara Lowitz: Thank you.

Susan Miller: The process of the hospital is that of the individual institution.

Andrea Yost: OK. Next question please.

Operator: Your next question comes from the line of Virginia Alley. Your line is open.

Dr. Hill: Hello, this is Dr. Hill, from Reno, Nevada. And it's a two-phase question on page – or slide 34, and 35. First one where you say the therapy begins within 36 hours of midnight of the day of admission. It's assumed the patient is receiving all three disciplines, PT, OT and ST, is that, meaning one therapy needs to start or all three need to start?

Susan Miller: The level of therapy must be intensive as has been defined. So, on, you know, 36 hours after the midnight of admission, you can't just do one hour of therapy.

Dr. Hill: I'm sorry if I didn't explain that clearly. The question is, do all three disciplines need to initiate therapy within 36 hours?

Sheila Lambowitz: That would be the optimal arrangement, but we do recognize that, you know, there may be, you know, issues in the facility where you can't get everything perfectly lined up. So, if one therapy is starting earlier than the other, I don't think we're considering that a problem. But if you only have one therapy done within 36 hours and, you know, any additional therapies don't start until day five, that would be very problematic.

Dr. Hill: OK. Thank you. And then the second part of that is, on page 35, speaking of group therapies as an adjunct or a supplement. In our setting, sometimes it's

all 15 to 20 percent of the time could be in a group for a patient. Do those times in group therapy count towards your 15 hours a week?

Susanne Seagrave: No.

Dr. Hill: So, you're saying group therapy does not count to meet the 15-hour a week row?

Susanne Seagrave: However, as I said in my slide presentation, we have not established specific standards for a group or concurrent therapy in IRFs yet, so this will not be a reason for denial.

Dr. Hill: OK. So, if I understand clearly, it's still under review and being considered.

Susanne Seagrave: Right. But we have stated...

Dr. Hill: As we sit here today, the facility includes group therapy, that facility could count those towards the 15 hours per week. Is that correct?

Andrea Yost: Yes, hold one second.

Sheila Lambowitz: We'll get back to you with a specific response. In general, what we have been saying is that, we expect that the therapy is going to be individualized. We do understand for certain kinds of conditions and certain patients that group therapy is appropriate. And when we see that documented, we would accept that as certainly an appropriate method of treatment. But again, it has to be appropriate to those patient needs. So that should help you a little, and will get a formal response to you as fast as we can.

Dr. Hill: Thank you, ma'am. That concludes my question.

Sheila Lambowitz: OK. Thank you.

Operator: Your next question comes from the line of Marie Myer. Your line is open.

Lou Pascolino: Hello. My name is Lou Pascolino, and I have just a dovetail back on that question is, could you accurately define what CMS would categorize as a group and what they would categorize as concurrent therapy?

Susanne Seagrave: We have not established any standards for staffing ratios, for how many patients count as group, for what we consider concurrent therapy. We are saying we have not yet established any standards of that for IRF. So, when we do, we will issue it in the proposed rule, and you'll have opportunity to comment.

Lou Pascolino: So the expectation right now, you're saying, is being one to one. And then after what that gentleman prior me about group therapy, I guess it was an understanding, I think, throughout that group therapy as long as those are appropriate that they had a common goal and that there was progress stated in that, and that it was not necessarily their entire program but in adjunct to one to one therapy was traditionally seemed to be accepted especially by the local, you know, local Medicare reviews that was brought off the NCD.

Sheila Lambowitz: Right, I think...

Lou Pascolino: So, has that changed?

Sheila Lambowitz: No, I mean, I don't think so. We've always – you know, we are saying that as an adjunct therapy, you know, when documented appropriately, you know, that's acceptable.

What we're trying to get at is that patients admitted to the IRF really are expected to need complex therapy intervention. They're expected to need an interdisciplinary form of therapy rehabilitation. And if the bulk of the care is being done as a group session, we have questions whether that would provide the intensity and complexity of service expected in an IRF.

Lou Pascolino: Well, thank you. And just one more question and then I'll let you go.

I've heard of other facilities doing concurrent therapy as two patients – one therapist is seeing two patients for almost at the same time but working on two separate identifiable plans of care for those patients. Is that concurrent or would you consider that a group or is that something that you feel really needs to be further defined? Because I think it's somewhat prolific throughout the rehab community, even though we haven't looked at it yet.

Susanne Seagrave: I think we feel that's something that needs to be further defined. As we've said over and over again, we are going to work on standards for the future, for the IRF setting, for both group and concurrent therapy, and we are going to be monitoring the use of these closely. But it is not something, at this point, that we have established standards on.

Susan Miller: We did receive many comments on this subject when we put the regulation out for comments, and we appreciate them, and are looking at them for future definition of the regulation.

Lou Pascolino: So for facilities that are doing these practices at that time, what are your suggestions to them at this point?

Susan Miller: We are saying that we expect that the bulk of treatment must be one on one. That is our standard. If there are special circumstances or needs of the patients that make group therapy useful to them, that needs to be well-documented in the charts.

Susanne Seagrave: Useful to the patients.

Susan Miller: Yes, useful to the patients, as opposed to the IRF – sorry. And we expect for all of the therapy put together to meet the level of intensity that we are looking for in an IRF.

Lou Pascolino: So when you define one to one, you're saying one therapist to one patient of which that period of time is solely engrossed into that plan of care which no longer can be shared or switched back and forth, and still be counted as an entire whole for both patients.

Susan Miller: We are looking for one-to-one therapy. One patient. One therapist.

Lou Pascolino: Thank you.

Andrea Yost: In order to allow for other callers to come in, we're going to have to move on to the next caller. Operator, can you move on to the next call, please?

Operator: Your next question comes from the line of Sarah Nickels. Your line is open.

Rosianna Zondag: Hi, this is Rosianna Zondag, with the American Physical Therapy Association. I just had a question about the weekly team meetings when you were talking about other healthcare providers participating in those meetings. If you have a situation where a physical therapist assistant was working under the physical therapist maybe to appropriately supervise, and there was some reason why the physical therapist couldn't participate in the team meetings for a particular week, would it be permissible for the physical therapist's assistant to sit in that meeting with having direct knowledge of the patient's care?

Susanne Seagrave: One of the things that I skipped over a little bit in my talk because I wanted to keep it as short as possible, was that in order to really foster the kind of shared interaction among people with the relevant training and experience in these interdisciplinary team settings, we really feel it's important to have people at the team meetings who represent the relative – the various disciplines, the physical therapy disciplines or the treating disciplines of the patient that have really the level of training and experience that can contribute to the interaction that happens during the interdisciplinary team meetings that is so important for fostering the goals of the patient.

And so, therefore, we don't believe that physical therapy assistants or any kind of therapy assistants have the level of training that licensed therapists would have to really, you know, fully contribute to the interactive discussion in the team meetings. So, no.

Rosianna Zondag: OK. Thank you.

Susanne Seagrave: Next call please.

Operator: Your next question comes from the line of Patricia Eaton. Your line is open.

Patricia Eaton: This is Patricia Eaton. We were wondering if the therapy provided over seven days for a total of 15 hours could be provided in the instance of a holiday? Or, does it have to be in light of the patient's medical condition dictating that seven hours over 15 days?

Female: Fifteen hours.

Patricia Eaton: Not fifteen hours – seven days. I'm sorry.

Sheila Lambowitz: I'm sorry. It is in light of the patient's medical condition, not because of weekends and holidays.

Patricia Eaton: Thank you.

Andrea Yost: Next question please.

Operator: Your next question comes from the line of Elizabeth McFarland. Your line is open.

Bradley Aiken: Hi, this is Dr. Brad Aiken, at Baptist Hospital in Miami. I wanted to get a little bit more clarification about the post-admission note and basically, in follow-up to what some of the other physicians were asking earlier. I also am in an acute care facility where we generally do comprehensive history and physical in our consultation during the time the patient's in acute care.

When that patient is transferred to the rehab center and we do an admission note, is it necessary – are you saying it's necessary for us to re-dictate all the history, physical and co-morbidity? Or, can that note simply refer to the consultation and then provide an update of the patient's medical condition?

Susan Miller: Because your process is different from those in other hospitals which don't have the ability to have a physician at the acute care facility, we – well, let me back track. We have made only one rule, and that one rule is for everyone. Therefore, we do expect a history and physical to be performed when the patient is admitted to the IRF.

How you perform that history and physical exam or in what detail you perform it is up to you. If you feel, for example, that there is no reason to look in the patient's ears, then you wouldn't have to do that. But a history and physical exam would be part of the post-admission evaluation.

Bradley Aiken: If the consultation is done or the admission note is done on the same day, let's say – I mean, there's times where maybe three o'clock in the afternoon I do a consultation and the patient is admitted at four, am I then expected to re-dictate an admission note at five?

Susan Miller: Unfortunately, at some level, yes.

Sheila Lambowitz: But I think what we're trying to tell you is that we would expect you to be able to build on what you already have and you wouldn't have to start from absolute scratch and re-dictate every note you made on the, you know, the evaluation you did an hour ago. But you do need to make it clear that you are now reviewing this from the IRF perspective.

Andrea Yost: Is there a follow-up?

Bradley Aiken: No. I'll just add to the earlier physician's comment that I think this is really absurd the amount of paperwork involved, it could now take four hours to do an admission that would have taken us one hour before, and we're providing no additional information that would be useful on the patient's care.

Andrea Yost: OK.

Susan Miller: May I ask you a question? When you do the acute care facility screening or your consult, is that not the property of the acute care facility? Do you bring a copy of it over to the IRF?

Bradley Aiken: Yes. The IRF is in the acute care facility and a copy of patient's chart...

Susan Miller: Right. Right. But there are two different charts that are generated, correct?

Bradley Aiken: Yes, and it's placed on both charts.

Susan Miller: OK. But you must have the history and physical exam at the level that you wish it to be in the IRF chart.

Bradley Aiken: Correct.

Susan Miller: Yes.

Bradley Aiken: But the time of the note may not be after the admission. The time of the note may be prior to the admission even if it's on the same day.

Susan Miller: Yes. I understand what you're saying. But the rule, so that it affects everybody equally is such that there must be some sort of history and physical exam on the chart at the IRF hospital when the patient comes in and is admitted. And again, the level of detail that you wish to put into it is your choice. Certainly, you can perhaps do a short physical exam but expand more heavily on the patient's goals. And as other callers have suggested, use this opportunity to do the over – to begin the overall plan of care.

Sheila Lambowitz: Yes. I think a lot of good points have been made, you know, in this area of the discussion, because it is not our intention to create duplicate documentation, you know, or to totally expand, you know, the type of data you should be looking at to make an admission decision. So I think we've given you as much guidance as we can on this phone call. We'll try to get back and, you know, address this issue again after the phone call so that we can really clarify that we want people to try to consolidate and streamline the process as long as you don't lose the comprehensive nature of the preadmission screen or the evaluations. So we will look at this carefully.

Bradley Aiken: All right. Thank you.

Sheila Lambowitz: Sure.

Susan Miller: Sure.

Operator: Your next question comes from a line of Nina Elley. Your line is open.

Dr. Stedwell: This is Dr. Stedwell, from Peoria, Illinois. And my question specifically relates to the collaboration with advanced practice nurses on our daily progress notes. I know that the requirement is that five days a week the physician sees the patient or three days a week, the physician sees the patient. I see the patient with my APN at least five days a week, six days a week. The level of documentation that I need to do in those daily notes is it more than acknowledgement that I was there. I saw the patient and the plan of care was reviewed and formulated together. Can the APN write the majority of that progress note?

Susan Miller: Three days a week, we would expect your note to combine the patient's medical progress, medical needs, medical conditions with that of the rehabilitation process. If you then see the patients six days a week as a team, the other three days a week, your specialist nurse could certainly document for you. But three days a week, we would wish to see from the rehab physician this melding of medical condition and rehabilitation progress and needs.

Sheila Lambowitz: And this sort of fits in with the last question so, you know, we will bring this back for consideration, you know, that the important thing is that we want the physician to be making the decisions, and we want the physician to be the decision point in how care is going to go forward. And you're asking, you know, questions about who writes it down. And I understand your concerns, but I think we've given you the best answer we can for now. So, we'll get back to you later.

Andrea Yost: We only have time for a few more questions, so we'll take the next several calls, next two calls, and then we'll refer you to the next to the last page of the PowerPoint, and you can send any further questions to the addresses listed there. So we'll take the next two questions, please.

Operator: All right. Your next question comes from the line of Clarisse Karen. Your line is open.

Bob Albert: Yes, this is Bob Albert, calling from Providence Saint Joseph Medical Center in Burbank, California. In regards to the slide 36, the brief expectation – exceptions to the intensive therapy requirement, if a patient would have an event that would qualify as an unexpected clinical event, would this preclude them from having to achieve a 15-hour average of therapy for that week?

Susan Miller: Oh, I'm sorry. Yes, we – that would be a brief exception. That would mean that within three days again they were back on track.

Bob Albert: So they wouldn't have to average 15 hours of therapy that week if that was the event?

Susan Miller: Correct.

Sheila Lambowitz: That's correct.

Bob Albert: Thank you.

Operator: Your next question comes from the line of Deanne Destler. Your line is open.

Andrea Yost: Caller, are you there?

Bob Harmon: Yes. This is Dr. Bob Harmon, at Doctors Hospital Rehab. To clarify regarding, I guess if you will, the therapist's activities in family training and caretaker training. With the patient there, does the amount of time that the therapists are working with family and caretaker training count toward that 15 hours per week?

Susan Miller: Yes, and in fact we even expect that as the IRF admission comes to a close that family training would maybe even dominate the IRF care. That would be very appropriate.

Bob Harmon: Thank you very much.

Andrea Yost: Operator, we can take one more call and then we'll do some closing remarks from here.

Operator: All right. Your final question comes from the line of Mary Kotowski. Your line is open.

Mary Kotowski: Hi, this is Mary Kotowski, calling from Fairview Hospital Acute Rehab Unit. I just had a question on slide 15, the preadmission screening. The first item listed is "prior level of function". Does this mean the patient's pre-hospital prior level of function before they experienced whatever condition brought them to the hospital?

Susan Miller: Yes.

Mary Kotowski: OK. I just want to double check on that. And then I want to clarify something, I guess what you had said – what another caller had asked about the post-admission screen being completed by the attending M.D. Does the preadmission screen, must that be completed by the physician who is going to

care for the patient while they're on the rehab unit or can that be completed by another rehab unit physician? Because we have physiatrists that cover for each other sometimes, and so maybe the one who's going to follow the patient while they're here is off on the weekend and another physician admits them. Is that allowed?

Susan Miller: Yes, that would be fine.

Mary Kotowski: OK.

Susan Miller: In some hospitals, it may be the vice-chair of the rehab or whatever as long as it is a rehab physician.

Mary Kotowski: OK. And then I guess I have one more question if you'll allow it.

Susan Miller: Go ahead. Sure.

Mary Kotowski: Regarding the team meeting process, you said that all the people that are involved with the direct care of the patient should be in there. So, would that mean that the nurses that are providing the bedside care to the patient should be involved in that? Or, would it be OK for the nurse manager who is familiar with the patient to attend the meeting as the representative?

Susan Miller: It would be optimal for the team leader nurse who is actually caring for the patient to be there. However, if another nurse who has knowledge of the patient is available, then he or she would be at the meeting.

Susanne Seagrave: Another registered nurse.

Susan Miller: Yes. I'm sorry – as a registered nurse, yes.

Mary Kotowski: OK. All right. So with that – that's concluded my question.

Susan Miller: The key portion of that is who has knowledge of the patient.

Mary Kotowski: Right. That was why I was asking the nurse manager on the unit is very familiar here with our patients, and she is an RN.

Andrea Yost: OK. It looks like we can take another call.

Operator: All right. Your next question comes from the line of Leonard Diaz. Your line is open.

Niesen Charles: Hi, this is Dr. Niesen Charles, of Light Memorial in Los Angeles. A couple of questions; one is with the preadmission screen. I thought I heard that you can't – you don't do anything where you can check off information. Is that correct? Because we have a form where you can check but at the bottom the physician can write, concur, and mention how the different details about the patient at preadmission screen. Or does it have to be more like a report?

Susanne Seagrave: It really needs to be – oh, I'm getting an echo. I'm sorry. It's a strange echo. I'll try to ignore it. Can you put your phone on mute? OK.

Andrea Yost: Thank you.

Susanne Seagrave: Thank you very much.

Yes. The preadmission screen cannot be a checklist where you simply have boxes and check them and then sign at the bottom. It does need to be I guess, you know, what you said, it needs to be more of a written document that documents the individual unique reasons for the patient why you believe that they belong in an IRF.

Niesen Charles: Can – if you do your consult within 48 hours of admission, can that serve as the preadmission screen if you have all the criteria that you have listed here?

Susanne Seagrave: Yes.

Niesen Charles: And then lastly, in terms of documentation in the medical record, and you did say it has to be very clear, the patient's functional progress and so on. So at least three – I see patients five to six days a week. At least, what you're saying is at least three days, three times out of a week you've got to have a note that not only emphasizes the medical issues but also documents how the patient is doing functionally. For instance, gait modest is 15 feet with front-wheel walker at least three times a week. Is that correct? The other three times, I can just document the medical issues and reference the physical therapy or OT-or, ST note.

Sheila Lambowitz: Correct. But I think that was well put.

Susan Miller: Yes. But we are also looking for the interrelationship between the medical condition and the functional condition. So, to write just, you know, mod assist is 15 feet, we would also want to know – it's not so much just copying the therapist's notes, but it's looking at how that patient's diabetes, glucose monitoring, congestive heart failure -whatever is sort of interrelating with their progress in this therapy program.

Niesen Charles: Thank you.

Susanne Seagrave: OK. I just want to just clarify. When you talked about a consult, you were talking about a consult in the hospital prior to the IRF admission, right?

Niesen Charles: Yes. Actually, I just realized I didn't get an answer to that question.

Susan Miller: So, you did?

Niesen Charles: Yes.

Sheila Lambowitz: We just, you know, the answer that we gave you which was that, you know, that was appropriate, you know, to be the basis of your preadmission screen is fine. We just want you to make sure you were talking about the consult prior to the IRF admission.

Niesen Charles: Yes, and within the 48 hours before admission in theory...

Sheila Lambowitz: All right.

Niesen Charles:: Now, I answer a consult and, you know, patients of those medical issues, so they do not come to rehab for, say, four days. Then I would need to do an amendment within that 48 hours.

Sheila Lambowitz: Yes.

Niesen Charles: Within that point.

Sheila Lambowitz: Yes. You would have to update, yes, your consult.

Niesen Charles: OK. And actually, I'll just make one comment. And I know you heard from many, many physicians about how burdensome this really sounds. We really would appreciate it if that is addressed because, you know, you have to do the report for the preadmission screen, then you have to do the H&P and then you have to – we have so much more. You almost wonder how you're going to get to a patient with all of this. So we really would appreciate if that could really be looked at closely and addressed. Thank you.

Andrea Yost: OK. Thank you. We have heard your comments and we are taking them back. This will conclude today's call. Sheila, do you have anything you'd like to add?

Sheila Lambowitz: Yes, thank you. You know, I think – we really appreciate these questions, because we learn from them even if we didn't have, you know, explicit answers for everything. It will help move forward on finding, you know, getting the policy out and clearly understood. We got a lot of questions from you before the call. We're still working on some answers, so you're going to be getting a lot more information from us. And we also will be accepting additional questions, you know, that you may not have had a chance to ask on this call. And do we have a website where people can send in additional questions?

Susanne Seagrave: Well, no. I mean, I'm thinking the best thing to do, on the second to last slide, we have provided our contact information. I would suggest not sending it all to Sheila, because frankly she'll get very upset with me. So you can send your questions to me, Susanne Seagrave, at the e-mail address provided on the second to last slide. And I will, you know, make sure that the questions get compiled. And as Sheila said, we will be placing answers to as many of these questions as we can as soon as we can on our coverage requirements website that is indicated on the slide, and Andrea gave the address for that earlier in the discussion.

So it's on the IRF PPS website on the left hand side. It's under the link called "Coverage Requirements," the same place that you downloaded these slides from that same page. So, look for more information on that page soon.

Andrea Yost: If you are going to send in any further questions, in the subject line, put IRF, you know, hyphen questions so that when we're – Susanne is not inundated with e-mails, and she can decipher what those are from what her regular e-mail would be. It would be a great help to her, I'm sure.

And we want to thank you all for participating in the call today. We learned a lot along the way, and we will be getting back with you shortly. Now, we have to say goodbye. Thank you.

Susanne Seagrave: Thank you.

Operator: This includes today's conference, you may now disconnect.

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