

## **Follow-up information from the November 12 provider training call**

### **Required Documentation**

#### **I. Preadmission Screening**

1. Clarification regarding the IRF personnel that may conduct the preadmission screening.

A licensed or certified clinician (or group of clinicians) must conduct the preadmission screening. A licensed or certified clinician is an individual who is 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. It is the responsibility of the IRF and the rehabilitation physician to ensure that the personnel conducting the preadmission screening have the necessary training and qualifications.

2. Clarification regarding the timeframes for the rehabilitation physician to document his or her review and concurrence with the preadmission screening.

A rehabilitation physician must review and concur with the findings and results of the preadmission screening after the screening has been completed and prior to the IRF admission. By concurrence, we mean that the rehabilitation physician must either sign and date the original document or, if reviewing from an off-site location, sign and date a copy of the document and fax it to the IRF. This may be done either on the preadmission screening form itself or on a separate document or electronically, as long as it is done prior to the IRF admission.

We will not accept a physician review and concurrence after the patient is admitted to the IRF (i.e., it is not acceptable for the rehabilitation physician to document his or her review and concurrence on the history and physical or the post-admission physician evaluation or on any other documentation that is generated after the patient is admitted to the IRF). It is also not acceptable for the rehabilitation physician to indicate his or her review and concurrence verbally (like a verbal order) by telephone, or for another clinician (such as an Admission Liaison) to document the rehabilitation physician's verbal review and concurrence with the preadmission screening. Verbal review and concurrence will not be accepted, even if it is followed by written review and concurrence after the IRF admission.

The rehabilitation physician's review and concurrence must be documented by himself or herself prior to the IRF admission. Further, since this documents the decision-making of the rehabilitation physician, this review and concurrence may not be delegated to a physician extender.

It is the IRF's responsibility to make sure that the admission decision is documented in the patient's medical record at the IRF, and that the record clearly shows that the

decision was made before the admission and reflects the decision-making of a rehabilitation physician.

3. Clarification regarding the use of physician extenders (as defined in Section 1861(s)(2)(K) of the Social Security Act) in the preadmission screening.

The decision regarding whether a patient meets the criteria for admission to an IRF requires a level of physician judgment that cannot be delegated to a physician extender (which, according to Section 1861(s)(2)(K) of the Social Security Act, includes physician assistants, nurse practitioners, and clinical nurse specialists). Thus, a rehabilitation physician (not a physician extender) must document his or her review and concurrence with the findings and results of the preadmission screening prior to the IRF admission. This will not be accepted if done by anyone other than a rehabilitation physician, except in rare situations such as unplanned illness when a rehabilitation physician may not be available. In this case, a physician designated by the IRF to substitute for the rehabilitation physician may document review and concurrence with the preadmission screening. The reason why a rehabilitation physician did not document review and concurrence with the preadmission screening must be documented in the medical record at the IRF. It is important to note that this must not be a regularly repeated occurrence and must not occur because of a planned vacation or leave of absence. For a planned vacation or leave of absence, the IRF must arrange to have another rehabilitation physician available to review and concur with the preadmission screenings.

A dated and timed signature by the rehabilitation physician with one sentence saying that he or she has reviewed and concurs with the findings and results of the preadmission screening is acceptable.

Physician extenders (as defined in Section 1861(s)(2)(K) of the Social Security Act) may conduct the preadmission screening, if they are licensed or certified and if they are 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. Physician extenders may make recommendations to the rehabilitation physician. However, the rehabilitation physician and the IRF are ultimately responsible for admission decisions.

4. Clarification regarding whether CMS will be providing standardized forms for the preadmission screening.

CMS will not be providing standard forms for the preadmission screening. We believe that each IRF should retain the flexibility to determine the best way to meet the preadmission screening requirements within its own organizational structure.

5. Clarification regarding the two methods that may be used to conduct the preadmission screening.

The preadmission screening may be conducted in one of the following two ways:

1. In person—through a face-to-face visit from the IRF clinical staff conducting the preadmission screening, or
2. By telephone—with transmission of the patient’s medical records from the referring hospital and a careful review of those records by the IRF clinical staff responsible for conducting the preadmission screening. The patient’s medical records from the referring hospital must be retained in the patient’s medical record at the IRF.

If the preadmission screening is conducted by telephone, the patient’s medical records from the referring hospital must be retained in the patient’s medical record at the IRF. We expect that appropriate references to the referring hospital’s medical record will be made in the preadmission screening. This data needs to be in the IRF medical record so that it can be available during IRF internal reviews and during CMS medical reviews of IRF claims. We expect that the clinicians assembling the data and performing the preadmission screening will extract the pertinent data from the referring hospital medical record. It is not necessary to include the entire referring hospital medical record if the preadmission screening is conducted by telephone. However, when evaluating the appropriateness of the admission decision, CMS reviewers can only consider those portions of the referring hospital medical record that are in the IRF medical record. Thus, it is the IRF’s responsibility to ensure that all relevant information was considered when the preadmission screen was conducted.

6. Clarification regarding whether a rehabilitation physician consultation note can serve as the preadmission screening documentation as long as it is written within the time frame and contains the required information.

A rehabilitation physician consultation note may serve as the preadmission screening as long as the rehabilitation physician consultation note contains the required information and is written within the 48 hours immediately preceding the IRF admission (or is written more than 48 hours immediately preceding the IRF admission and is updated within the 48 hours immediately preceding the IRF admission).

7. Clarification regarding the rehabilitation physician’s overall approval of the preadmission screening information versus the need to comment on each individual facet of the preadmission screening information.

The rehabilitation physician is not required to comment on each individual facet of the preadmission screening. In certain instances when a particular facet of the preadmission screening is a key factor in influencing the rehabilitation physician’s decision to admit the patient to the IRF, it would be good practice and would certainly be allowable for the rehabilitation physician to comment on that facet. However, to fulfill the requirement, the rehabilitation physician merely needs to document his or

her concurrence with the findings and results of the preadmission screening as a whole, not each individual facet.

8. Clarification on what detailed information must be present in the preadmission screening.

The preadmission screening must include the patient's prior level of function (prior to the event that caused the need for rehabilitation), the patient's expected level of improvement, the expected length of time needed to achieve that level of improvement, the risk for clinical complications, the conditions that caused the need for rehabilitation, the combinations of treatments needed in the IRF, the expected frequency and duration of treatment in the IRF, the anticipated discharge destination from the IRF, any anticipated post-discharge treatments, and other information relevant to the patient's care needs. The preadmission screening documentation must also include documentation of a rehabilitation physician's review and concurrence with the findings and results of the preadmission screening prior to the IRF admission.

This same information is required to be in the preadmission screening documentation for patients admitted to IRFs directly from the community.

9. Clarification regarding the qualifications of the rehabilitation physician.

The rehabilitation physician is a licensed physician (not necessarily a salaried employee of the IRF) who has specialized training and experience in rehabilitation. It is the responsibility of each IRF to ensure that the rehabilitation physicians that are making the admission decisions and caring for patients are appropriately trained and qualified. While the IRF must continue to meet the hospital conditions of participation specified in 42 Code of Federal Regulations §482.22 regarding documentation of staff qualifications, we do not require specific documentation in the patient's medical record to demonstrate the rehabilitation physician's qualifications.

10. Clarification regarding whether all IRF referrals have to be reviewed by a rehabilitation physician, or only those who are found to be appropriate for IRF admissions.

The IRF is required to maintain documentation of a rehabilitation physician's review and concurrence with the IRF admission for all Medicare beneficiaries admitted to the IRF. The IRF is not required to keep such documentation for Medicare beneficiaries who are not admitted to the IRF.

11. Clarification regarding whether the preadmission screening, the history and physical, and the post-admission physician evaluation can be combined into one document if a patient is referred to an IRF and transferred all in the same day.

The history and physical and the post-admission physician evaluation certainly can be combined into one document. However, the preadmission screening must be

completed prior to the IRF admission and the post-admission physician evaluation must be completed after the IRF admission.

12. Clarification regarding whether the justification for the IRF admission has to be repeated on both the preadmission screening documentation and the post-admission physician evaluation.

Yes. The justification for the IRF admission must be repeated on both the preadmission screening documentation and the post-admission physician evaluation. However, if the patient's status has not changed, a brief note that references the preadmission screening justification and confirms that the patient status has not changed will be sufficient.

13. Clarification regarding whether the preadmission screening documentation at the IRF can be the same document "carried over" from the acute care hospital, and whether this documentation needs to be in both places.

As long as the preadmission screening documentation at the IRF contains all of the required information, is conducted by a licensed or certified clinician (or clinicians) within the required timeframes, and is reviewed and concurred with by a rehabilitation physician prior to the IRF admission, it meets the requirements regardless of whether the same document appears in the acute care hospital record. This documentation is required to be retained in the patient's medical record at the IRF. The acute care hospital is required to retain the documentation described in 42 Code of Regulations § 482.24 in the patient's acute care hospital medical record.

14. Clarification regarding the required format for the preadmission screening information (e.g., electronic, hard copy, etc.) and the rehabilitation physician's documentation of his or her review and concurrence with the findings and results of the preadmission screening (e.g., signature on the form, faxed signature with date and time, etc).

Since IRFs' record keeping systems vary, CMS believes that each IRF should retain the flexibility to determine the best way to document both the preadmission screening and to determine that the rehabilitation physician has reviewed and concurs with the findings and results of the preadmission screening within its own organizational structure. Note that, according to 42 Code of Federal Regulations §482.24(c)(1), Medicare payment policy no longer permits the use of rubber stamps as a means of authenticating medical records that support a claim for payment.

15. Clarification regarding "check boxes" on the preadmission screening form.

On the November 12 provider training conference call, CMS indicated that the preadmission screening documentation must not be presented entirely in the form of "check boxes," but instead must contain some narrative information. Thus, for example, the documentation cannot merely contain "yes/no" check boxes for whether the patient has a risk for clinical complications. It must describe in detail what

conditions/comorbidities the patient has and why these indicate a specific risk for clinical complications that require physician monitoring in order for the patient to actively participate in an intensive rehabilitation therapy program. This detailed description, by the very nature of it, would need to be in narrative form. However, the rehabilitation physician is not required to write this narrative if the narrative is written by the licensed or certified clinician/clinicians conducting the preadmission screening.

16. Clarification regarding whether the rehabilitation physician or the licensed or certified clinician/clinicians must write out the detailed reasoning/justification for the IRF admission on the preadmission screening documentation.

The licensed or certified clinician/clinicians conducting the preadmission screening must write out the detailed reasoning/justification for the IRF admission on the preadmission screening documentation. The rehabilitation physician is only required to review and concur with this reasoning/justification. Of course, even though it is not required, the rehabilitation physician may conduct the preadmission screening, in which case he or she would write the reasoning/justification narrative. In all cases, however, the rehabilitation physician is responsible for the accuracy and completeness of the preadmission screening documentation.

17. Clarification regarding whether the preadmission screening documentation must be a permanent part of the patient's medical record at the IRF.

Yes. The preadmission screening documentation must now be a permanent part of the patient's medical record at the IRF.

18. Clarification on whether the diagnoses on the preadmission screening and the post-admission physician evaluation must agree.

The diagnoses on the preadmission screening and the post-admission physician evaluation must correspond with other information in the patient's medical record, and generally will be the same. However, there could be rare instances when the two sets of diagnoses could be different, reflecting significant changes in the patient's condition between the preadmission screening and the post-admission physician evaluation. The reasons for these changes should be documented in the post-admission physician evaluation.

19. Clarification regarding whether family physicians or internal medical physicians or other types of physicians (besides rehabilitation physicians) can review and concur with the preadmission screening in place of a rehabilitation physician.

A rehabilitation physician is uniquely qualified to determine whether a patient is appropriate for IRF care or not. Thus, according to the regulations, it must be a rehabilitation physician with specialized training and experience in rehabilitation who reviews and concurs with the preadmission screening prior to the IRF admission.

However, we recognize that, in rare situations such as unplanned illness, a rehabilitation physician may not be available. In this case, a physician designated by the IRF to substitute for the rehabilitation physician may document review and concurrence with the preadmission screening. The reason why a rehabilitation physician did not document review and concurrence with the preadmission screening must be documented in the medical record at the IRF. It is important to note that this must not be a regularly repeated occurrence and must not occur because of a planned vacation or leave of absence. For a planned vacation or leave of absence, the IRF must arrange to have another rehabilitation physician available to review and concur with the preadmission screenings.

## **II. Post-Admission Physician Evaluation**

1. Clarification regarding whether a history and physical that includes all of the required elements for the post-admission physician evaluation would satisfy the requirement for a post-admission physician evaluation and whether this document must be re-named “post-admission physician evaluation.”

A history and physical that includes all of the required elements for the post-admission physician evaluation and that is done by a rehabilitation physician within the first 24 hours of the IRF admission meets the requirement for the post-admission physician evaluation. It must be apparent to a medical review entity that the expanded history and physical is being used for the post-admission physician evaluation, so it would be good practice (though not required) to indicate this in the title of the document.

If a resident or a physician extender (defined in section 1861(s)(2)(K) of the Social Security Act to include physician assistants, nurse practitioners, and clinical nurse specialists) has completed the history and physical, a rehabilitation physician is not required to repeat the history and physical exam, but he or she must visit the patient and complete the other required parts of the post-admission physician evaluation within the 24 hours immediately following the IRF admission.

2. Clarification regarding the use of physician extenders, including residents, in completing the history and physical and the post-admission physician evaluation.

The usual Medicare regulations regarding the use of physician extenders and residents in providing services to Medicare beneficiaries apply to completion of the history and physical. However, a rehabilitation physician must visit the patient and complete the other required parts of the post-admission physician evaluation within the 24 hours immediately following the IRF admission.

3. Clarification regarding the required content for the post-admission physician evaluation.

The post-admission physician evaluation must identify any relevant changes that have occurred since the preadmission screening. It also must include a documented history and physical exam, and a review of the patient's prior and current medical and functional conditions and comorbidities. As such, it also serves as the basis for the individualized overall plan of care. Note that, according to the regulations in 42 Code of Federal Regulations §482.24(c)(1), the post-admission physician evaluation (like all entries in the medical record) must be dated, timed, and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided.

4. Clarification regarding the availability of standard forms for the post-admission physician evaluation.

CMS will not be providing standard forms for the post-admission physician evaluation. We believe that each IRF should retain the flexibility to determine the best way to meet this requirement within its own organizational structure.

5. Clarification regarding whether the history and physical exam can be done by one physician and the post-admission physician evaluation can be done by another physician or whether the same physician must do both.

The history and physical and the post-admission physician evaluation do not have to be performed by the same individual.

6. Clarification regarding whether the rehabilitation physician or the interdisciplinary team or both are responsible for completing the post-admission physician evaluation.

The post-admission physician evaluation is the sole responsibility of the rehabilitation physician. Although it would certainly be good practice for the rehabilitation physician to consider any available input from the interdisciplinary team members, the interdisciplinary team is not required to be involved in the post-admission physician evaluation.

7. Clarification regarding to what extent an evaluation (or a history and physical) has to be repeated after admission to an IRF if the patient has been evaluated by the same rehabilitation physician just prior to admission to the IRF.

The rehabilitation physician is responsible for ensuring that the information in the post-admission physician evaluation is accurate, up-to-date, and fully supports the IRF admission decision. Thus, he or she must update any information necessary to ensure that the information is up-to-date. However, if the patient's status has not changed, a brief note that references the previous evaluation and confirms that the patient's status has not changed will be sufficient.

8. Clarification of whether the post-admission physician evaluation and the overall plan of care can be completed at the same time and be in the same document.

As long as both pieces of documentation (the post-admission physician evaluation and the overall plan of care) contain all of the required elements and are completed within the required timeframes, they can be completed at the same time and be included in the same document. However, it must be clearly documented that both requirements are included in the document.

9. Clarification regarding whether a post-admission physician evaluation is still required to be completed within 24 hours of the IRF admission to document any changes or confirm the findings of the history and physical if the history and physical was just completed hours before the patient's transfer to the IRF.

A post-admission physician evaluation is required to be completed for all IRF admissions, regardless of how recently prior to the admission the patient was evaluated. However, the rehabilitation physician may use information from the referring hospital evaluation when completing the post-admission physician evaluation.

### **III. Individualized Overall Plan of Care**

1. Clarification regarding whether the first interdisciplinary team meeting has to occur within the first 4 days of admission to complete the overall plan of care.

Though it might be good practice, the first team meeting does not have to occur in the first 4 days to establish the overall plan of care. The overall plan of care is the rehabilitation physician's responsibility.

2. Clarification of the difference between the overall plan of care and the interdisciplinary team meeting.

The purpose of the overall plan of care is for the rehabilitation physician to bring together all of the information that has been collected on the patient's medical and functional treatment needs and goals in the beginning of the IRF stay, and to synthesize this information into an overall plan of care that will guide the patient's treatment during the IRF stay. The required elements of the overall plan of care are described in section 110.1.3 of the Medicare Benefit Policy Manual (Pub. 100-02). The overall plan of care must build on information from the preadmission screening and the post-admission physician evaluation, and must include information gained from the individual therapy assessments. This forms the initial treatment plan for the patient.

The interdisciplinary team must then meet weekly in order to do the following:

- Assess the patient's progress towards the rehabilitation goals,
- Consider possible resolutions to any problems that could impede progress towards the goals,

- Reassess the validity of the rehabilitation goals previously established, and
  - Monitor and revise the treatment plan, as needed.
3. Clarification regarding whether the rehabilitation physician has to write out the entire plan of care him/herself.

The rehabilitation physician does not have to write out (or dictate) the entire plan of care him/herself, although it is certainly acceptable if he or she chooses to do so. There are many possible ways of developing the overall plan of care, and we believe that the IRF and the rehabilitation physician should retain the flexibility to determine the best way to meet this documentation requirement within the organizational structure of the IRF.

Depending on the organizational structure of the IRF, the rehabilitation physician may, for example, write out (or dictate) the overall plan of care or bring together (synthesize) the individual plans of care from the different treating disciplines and modify or add to these individual discipline plans of care, as appropriate.

The purpose of the overall plan of care is to provide a general direction for the patient's care in the IRF and to document broad goals for the patient's treatment in the IRF that will then be used by each discipline to further refine their individual plans of care, as appropriate.

4. Clarification regarding the availability of standard forms for the overall plan of care.

CMS will not be making standard forms available for the individualized overall plan of care. These should be individualized to the unique circumstances and care needs of the patient. Further, we believe that each IRF should retain the flexibility to determine the best way to meet these requirements within its own organizational structure.

5. Clarification regarding what CMS means by an "individualized" overall plan of care.

We emphasize the word "individualized" in the context of the overall plan of care because each overall plan of care must be tailored to the unique care needs of the patient. No two overall plans of care are exactly alike.

6. Clarification regarding whether the overall plan of care can be combined with the history and physical and/or the post-admission physician evaluation documentation and whether the overall plan of care has to repeat information from these documents.

The individualized overall plan of care must build off of the history and physical and the post-admission physician evaluation. Thus, it can be an extension of these documents, and does not necessarily have to repeat all of the information contained in these documents. Further, it can be completed at the same time as the post-admission physician evaluation (i.e., within the first 24 hours of the IRF admission).

7. Clarification regarding whether the overall plan of care can be done anytime within the first 4 days of admission to the IRF (i.e., on day 2 or 3, if all of the information is known at that time).

The overall plan of care must be completed by the end of the 4th day immediately following the IRF admission. It is acceptable to complete the overall plan of care on days 1, 2, 3, or 4 of the IRF admission.

8. Clarification regarding whether a physician extender can assist the rehabilitation physician in developing the overall plan of care for his or her approval and signature.

Yes. Physician extenders working in collaboration with the rehabilitation physician can assist the rehabilitation physician in developing the overall plan of care for his or her approval and signature. We believe that the IRF and the rehabilitation physician should retain the flexibility to determine the best way to satisfy this requirement within the organizational structure of the IRF.

9. Clarification regarding the meaning of the requirement to document the expected amount of therapy time “by discipline” and whether an IRF claim could be subject to denial if the expected amount of therapy time by discipline varies from one day to the next.

The expected amount of therapy time by discipline required during the IRF stay must be documented on the individualized overall plan of care. This means that the rehabilitation physician must document the amount of expected physical therapy, occupational therapy, speech-language pathology, and orthotics/prosthetics the patient is expected to need on a daily basis in the IRF. Day-by-day variation in the expected amount of therapy by discipline is acceptable as long as it reflects the unique care needs of the patient.

It is not acceptable to simply use a generalized phrase such as, “At least 3 hours per day, at least 5 days per week” on the individualized overall plan of care. This is not individualized to the unique care needs of the patient and does not indicate the expected amount of therapy by discipline. To meet the requirement, the overall plan of care must indicate the type and expected amount of physical therapy, occupational therapy, speech-language pathology, and orthotics/prosthetics needed by the patient on a daily basis. This must be unique to the individual care needs of the patient.

10. Clarification regarding the difference between the estimated length of stay and the duration of therapy treatments.

The duration of therapy treatments must be indicated by discipline, whereas the estimated length of stay is an overall number of days. For example, while the estimated length of stay for a hypothetical patient could be 21 days, the patient could

require speech-language pathology treatments for days 1 through 10, and require orthotics/prosthetics on days 10 through 21 of the stay.

#### **IV. Admission Orders**

1. Clarification regarding why the admission orders language was revised.

At the time of admission, a physician must generate admission orders for the patient's care that must be retained in the patient's medical record at the IRF. This admission orders requirement is not substantively different from the previous admission orders requirement. CMS 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 patient's medical record at the IRF.

2. Clarification regarding whether the admission orders can be given verbally, including whether they can be given to a registered nurse by the physician over the phone.

The physician may dictate the admission orders, but the orders themselves must be written and retained in the patient's medical record at the IRF.

3. Clarification regarding whether the admission orders can be generated by an internist or a family practice physician or another type of physician, or whether they must be generated by a rehabilitation physician.

Any licensed physician may generate the admission orders. It does not have to be a rehabilitation physician.

4. Clarification regarding whether a physician extender (such as a nurse practitioner or a physician assistant) can generate the admission orders.

A physician extender, working in collaboration with the physician, may generate the admission orders.

#### **V. Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)**

1. Clarification regarding whether the IRF-PAI form included in the patient's medical record at the IRF must have a data entry date and time.

According to 42 Code of Federal Regulations §482.24(c)(1), all entries in the medical record must be dated, timed, and authenticated, in written or electronic form, by the person responsible for providing or evaluating the service provided.