Follow-up information from the November 12 provider training call

Criteria

I. Multiple Therapy Disciplines

1. Clarification regarding the use of group therapies in IRFs.

Answer: CMS has not yet established standards for the provision of group therapies in IRFs. However, as we stated in the FY 2010 IRF PPS final rule, the standard of care for IRF patients is individualized therapy. We do not believe that an IRF providing the preponderance of therapy in the form of group therapy would be demonstrating the intensity of therapy required in an IRF.

2. Clarification regarding the use of concurrent therapies in IRFs.

Answer: CMS has not yet established standards for the provision of concurrent therapies in IRFs. However, we do not believe that an IRF providing the preponderance of therapy in the form of concurrent therapy would be demonstrating the intensity of therapy required in an IRF.

3. Clarification regarding the use of therapy technician/aide services and certified occupational therapy assistants and physical therapy assistants in IRFs and whether these services would count towards demonstrating the intensity of therapy requirement in an IRF.

Answer: For detailed guidance on the required qualifications of a therapist, required skills of a therapist, and medically necessary and appropriately documented therapy services, please see Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, sections 220 and 230. The policies in those sections describe a standard of care that should be consistent throughout the therapy disciplines, regardless of the setting of care. Therapy technician/aides are limited to performing administrative and support functions and cannot be directly involved in the provision of therapy services to the beneficiary. Certified occupational therapy assistants and physical therapy assistants may provide therapy services to beneficiaries under the appropriate supervision of licensed therapists.

4. Clarification regarding the requirement that patients need multiple therapy disciplines, at least one of which must be physical or occupational therapy.

Answer: A primary distinction between the IRF environment and other rehabilitation settings is the interdisciplinary approach to providing rehabilitation therapy services in an IRF. Patients requiring only one discipline of therapy would not need this interdisciplinary approach to care and therefore do not need to be treated in an IRF.

5. Clarification regarding whether certified occupational therapy assistants and physical therapy assistants may be the representatives of their respective therapy disciplines at the interdisciplinary team meetings.

Answer: The regulations state that the interdisciplinary team meetings must focus on the following:

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

Generally, state licensure laws preclude therapy assistants from evaluating patients and establishing or revising/modifying plans of care, which are some of the core functions of the interdisciplinary team meeting. Since therapy assistants cannot perform the core functions of the interdisciplinary team meetings, then they cannot represent their respective disciplines at the meetings.

6. Clarification of how an IRF must document that a patient needs occupational and physical therapy in the IRF when that patient has only received physical therapy in the referring hospital.

Answer: The pre-admission screening must demonstrate that there is a reasonable expectation that, on admission to the IRF, the patient needs multiple therapy disciplines, at least one of which must be physical or occupational therapy.

II. Intensive Rehabilitation Therapy Program

1. Clarification of the different ways in which an IRF may demonstrate the intensity of therapy requirement.

Answer: Although the intensity of rehabilitation services can be reflected in various ways, the generally-accepted standard by which the intensity of these services is typically demonstrated in IRFs is by the provision of intensive therapies at least 3 hours per day at least 5 days per week. However this is not the only way such intensity could be demonstrated.

The intensity of therapy provided in an IRF could also be demonstrated by the provision of 15 hours of therapy per week (that is, in a 7 consecutive day period starting with the day of admission), as long as the reasons for the patient's periodic need for this program of intensive rehabilitation is well-documented in the patient's medical record at the IRF and the overall amount of therapy is "intensive" and can reasonably be expected to benefit the patient. For example, if a hypothetical IRF patient was admitted to an IRF for a hip fracture, but was also undergoing chemotherapy for an unrelated issue, the patient might not be able to tolerate therapy on a predictable basis due to the chemotherapy. Thus, this hypothetical patient might be more effectively served by the provision of 4 hours of therapy 3 days per week and 1 ½ hours of therapy on 2 (or more) other days per week in order to accommodate his or her chemotherapy schedule.

2. Clarification on whether it is acceptable to round the number of minutes of therapy.

Answer: Therapy minutes cannot be rounded for the purposes of documenting the required intensity of therapy provided in an IRF.

3. Clarification on whether or not therapy evaluations and re-evaluations count as the initiation of therapy services and whether they count toward demonstrating the intensity of therapy requirement in IRFs.

Answer: Therapy evaluations do count as the initiation of therapy services. They may also be used to demonstrate the intensity of therapy services provided in IRFs.

4. Clarification on whether or not a therapist can complete the therapy evaluation of the patient while that patient is still in the referring hospital (for example, the acute care hospital) waiting to be transferred to the IRF and whether or not therapies done in the referring hospital count towards demonstrating the intensity of therapy requirement if performed on the same day that a patient is discharged from the referring hospital and admitted to the IRF.

Answer: Evaluations and/or therapy done in the referring hospital do not count in the IRF for purposes of meeting the intensity of therapy requirement.

5. Clarification regarding the day of admission as day "1" of the week for demonstrating the required intensity of therapy requirement and whether the initiation of therapy 36 hours from midnight of the day of admission starts the therapy "clock".

Answer: The day of admission is day "1" for the required intensity of therapy requirement. No matter what time of day the patient is admitted to the IRF, the day of admission counts as day "1" and represents the start of the therapy "clock".

6. Clarification regarding whether IRFs are required to provide therapy on weekends and/or holidays.

Answer: Regardless of weekends and holidays, IRFs are expected to comply with all of the coverage requirements. It is standard practice for IRFs to plan for weekends and holidays to execute patients' plans of care.

7. Clarification as to whether or not a patient who is admitted Wednesday, with therapy evaluations done on Thursday, must receive therapy on a weekend day (Saturday or Sunday) in order to document the intensity of therapy requirement.

Answer: In many instances, patients admitted later in the week must receive therapy services on at least one of the days of the weekend to document the required intensity of therapy program provided in the IRF.

8. Clarification as to whether or not neuropsychology is one of the therapies that can be used to document the intensity of therapy requirement.

Answer: While we believe that IRFs should provide, as needed, psychological and neuropsychological services to IRF patients, these services are separately billable under Medicare Part B, as described in § 411.15(m)(3)(i) and § 411.15(m)(3)(v), and are not included in the IRF PPS payment. Thus, while we would expect the IRF to provide appropriate medical oversight of any medical or psychiatric problem that is present on admission or develops during the stay (in accordance with the overall hospital Conditions of Participation at § 482.12(c)(1)(i), (c)(1)(vi), and (c)(4)), psychological and neuropsychological services furnished pursuant to this responsibility would not be considered part of the required intensity of therapy services that Medicare pays for under the Part A benefit that includes payment for IRF PPS services.

Adjunct Therapies

1. Clarification on whether or not recreational therapy, music therapy, respiratory therapy, neuropsychology, or cognitive therapy can be used to satisfy the requirement for patients to receive intensive rehabilitation therapy in IRFs. If not, are recreational therapy services a covered service in IRFs when the medical necessity is well-documented by the rehabilitation physician and they are ordered by a rehabilitation physician as part of the patient's overall plan of care?

Answer: While we believe that IRFs should provide, as needed, psychological and neuropsychological services to IRF patients, these services are separately billable under Medicare Part B, as described in § 411.15(m)(3)(i) and § 411.15(m)(3)(v), and are not included in the IRF PPS payment. Thus, while we would expect the IRF to provide appropriate medical oversight of any medical or psychiatric problem that is present on admission or develops during the stay (in accordance with the overall hospital Conditions of Participation at § 482.12(c)(1)(i), (c)(1)(vi), and (c)(4)), psychological and neuropsychological services furnished pursuant to this responsibility would not be considered part of the required intensity of therapy services that Medicare pays for under the Part A benefit that includes payment for IRF PPS services.

Further, we do not believe that it is appropriate to mandate that all IRFs provide recreational therapy, music therapy, or respiratory therapy services to all IRF patients, as such services may be beneficial to some, but not all, patients as an *adjunct* to other, primary types of therapy services provided in an IRF (physical therapy, occupational therapy, speech-language pathology, and prosthetics/orthotics). We do not believe that they should replace the provision of these core skilled therapy services. Thus, we believe that it should be left to each individual IRF to determine whether offering recreational therapy, music therapy, or respiratory therapy is the best way to achieve the desired patient care outcomes.

While we are not adding these therapies to the list of required therapy services in IRFs, we do recognize that they are Medicare covered services in IRFs if the medical necessity is well documented by the rehabilitation physician in the medical record and is ordered by the rehabilitation physician as part of the overall plan of care for the patient. However, consistent with our longstanding policies and standard practices, these therapy activities are not used to demonstrate that a patient has received intensive therapy services.

Medical Necessity

1. Clarification of the meaning of "medical necessity" and how this concept relates to the new coverage criteria.

Answer: Instead of using the term "medical necessity," we are now using the term "reasonable and necessary" to describe whether an IRF claim meets the Medicare requirements for payment.

2. Clarification on whether or not patients must have suffered "an acute impairment" for admission to an IRF or whether patients who experience a functional decline due to a chronic condition may be admitted to an IRF.

Answer: We did not intend to limit the IRF benefit to only those patients who have suffered an acute impairment prior to being admitted to an IRF. While this is the typical type of patient who receives treatment in an IRF, patients who have suffered a functional decline due to a chronic condition may be appropriately treated in IRFs if they meet all of the IRF coverage criteria specified in the regulation and in section 110 of the Medicare Benefit Policy Manual.

3. Clarification on whether CMS would consider the provision of 15 hours per week of intensive therapy services to be an appropriate treatment plan in an IRF for patients receiving dialysis treatments.

Answer: Depending on the patient's ability to tolerate therapy on the days that dialysis is performed, the provision of 15 hours per week of therapy could be considered an appropriate treatment plan in an IRF for many dialysis patients. The reasons for this therapy schedule, or any other therapy schedule, must be well-documented in the patient's medical record at the IRF, and the overall amount of therapy must be "intensive" and must be reasonably be expected to benefit the patient.

Rehabilitation Nursing

1. Clarification of the rehabilitation nursing requirements.

Answer: An IRF must comply with the requirements for nursing set forth in the Hospital Conditions of Participation at 42 CFR §482.23 of the regulations. In addition, the interdisciplinary team must include a registered nurse with specialized training or experience in rehabilitation.

Beneficiaries Needing Assessment

1. Clarification regarding what CMS meant by the term "trial" patients and whether patients may still be admitted to IRFs on a "trial" basis.

Answer: Previously, the Medicare Benefit Policy Manual had a provision for patients to be admitted to IRFs for 3 to 10 day periods to assess whether the patients could benefit from an IRF

level of care. These were sometimes called "trial" admissions. As we stated in the final rule, CMS will no longer cover a stay in the IRF where the primary purpose of the stay is to assess the patient's need for intensive rehabilitation. Instead, the IRF is expected to admit only those patients who, on admission, are reasonably expected to meet the stated coverage criteria.

The current average length of stay for IRF patients is only about 13 days, and the average length of stay for many orthopedic patients treated in IRFs is only about 8 days. Given this, we believe that it is no longer appropriate to allow up to 10 days in an IRF merely to assess the patient. At that point, the average IRF patient would already be preparing to be discharged. In addition, we believe that, in today's clinical environment, licensed physicians with training and experience in rehabilitation are able to assess a patient prior to admission to an IRF and determine whether there is a reasonable expectation that the patient can participate in and benefit from treatment in an IRF.

Other Issues

Inappropriate Admission

1. Clarification as to whether or not facilities can have longer than 3 days to place a patient who is not appropriate for IRF care (e.g., some patients need special psychiatric paperwork to be completed before a SNF will accept them).

Answer: The IRF is not prohibited from keeping the patient for longer than three days. However, the IRF is only eligible to receive Medicare reimbursement based upon the short stay payment for IRF stays of three days or fewer.

2. Clarification regarding payment for an admission if it takes longer than 3 days for the IRF to discharge a patient who no longer meets the coverage criteria and why CMS is restricting payment to the CMG for patient stays of 3 days or less.

Answer: In the unusual instance that the rehabilitation physician's reasonable expectation prior to admission is not realized once the patient is admitted to the IRF, the IRF must immediately begin the discharge process. Although CMS would typically deny payment for services that are not reasonable and necessary, we recognize that mistakes may occur despite the best efforts of the IRF in conducting a thorough preadmission screening. We also recognize that the patient's medical or functional condition could change between the preadmission screening and the time of the IRF admission. To account for these possibilities, we will allow the IRF to receive the IRF short stay payment for stays of three days or fewer.

Break in Therapy

1. Clarification as how a patient who is ill would meet the intensity of therapy requirement and whether or not the "missed hours" would need to be made up on the weekend.

Answer: While patients requiring an IRF stay are expected to need and receive an intensive rehabilitation therapy program, as described above, this may not be true for a limited number of days during a patient's IRF stay because patients' needs vary over time. For example, if an unexpected clinical event occurs during the course of a patient's IRF stay that limits the patient's ability to participate in the intensive therapy program for a brief period not to exceed 3 consecutive days (e.g., extensive diagnostic tests off premises, prolonged intravenous infusion of chemotherapy or blood products, bed rest due to signs of deep vein thrombosis, exhaustion due to recent ambulance transportation, surgical procedure, etc.), the specific reasons for the break in the provision of therapy services must be documented in the patient's IRF medical record. If these reasons are appropriately documented in the patient's IRF medical record, such a break in service (of limited duration) will not affect the determination of the medical necessity of the IRF admission. Thus, Medicare contractors may approve brief exceptions to the intensity of therapy requirement in these particular cases if they determine that the initial expectation of the patient's active participation in intensive therapy during the IRF stay was based on a diligent preadmission screening, post-admission physician evaluation, and overall plan of care that were based on reasonable conclusions.