



e
rehab
data.com

*Adapting to the 2010 Final Rule: How
Do Your Charts Look?*

Lisa Werner, MBA, MS, CCC-SLP

Better outcomes for everyone.

- **Pre-admission Screening:**

- The facility must have and utilize a thorough preadmission screening process for each potential patient that meets the following criteria:
 - It is conducted by a qualified clinician(s) designated by a rehabilitation physician described in paragraph (a) (1) of this section within the 48 hours immediately preceding the IRF admission.
 - It includes a detailed and comprehensive review of each prospective patient's condition and medical history.
 - It serves as the basis for the initial determination of whether or not the patient meets the IRF admission requirements [in paragraph (b)]...
 - It is used to inform a rehabilitation physician who reviews and documents his or her concurrence with the findings and results of the preadmission screening.
 - It is retained in the patient's medical record.

- **Comments regarding pre-admission screening:**
 - CMS recognized that they are placing more weight on the rehab physician's decision to admit .
 - To that end, the physician should document his/her rationale behind the decision to show reviewers what he/she was thinking.
 - CMS included the "qualified clinicians" perform pre-admission screening because they feel that non-clinical personnel can not adequately assess the risk for clinical and rehab complications and assess other aspects of the patient's medical and functional condition.
 - Also stated that a rehab trained physician should be making the decision to admit a patient to an IRF.

- **Method of screening:**

- Screening or update must be performed within 48 hours of the patient's admission.
- Must include, at a minimum, a review of the patient's records.
- Cannot do a telephone screen, but can conduct an update via the telephone.

- **Opportunities for Improvement –**
 - Time along with physician signature and date
 - Compare to the time on your face sheet
 - Be sure it is signed before admission
 - Include goals or anticipated outcomes
 - Must have a functional assessment
 - Complete within 48 hours of admission
 - Include anticipated post-discharge needs

• **Inpatient Rehabilitation Facility Admission Requirements:**

- The facility must ensure that each patient it admits meets the following requirements at the time of admission-
 - Requires the active and ongoing therapeutic intervention of at least two therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy), one of which must be physical or occupational therapy.
 - Generally requires and can reasonably be expected to actively participate in at least **3 hours of therapy (physical therapy, occupational therapy, speech-language pathology, or Prosthetics/orthotics therapy) per day at least 5 days per week** and is expected to make measurable improvement that will be of practical value to improve the patient's functional capacity or adaptation to impairments. The required therapy treatments must **begin within 36 hours of midnight of the day of the patient's admission** to the IRF.

- **Inpatient Rehabilitation Facility Admission Requirements (continued):**

- The facility must ensure that each patient it admits meets the following requirements at the time of admission-
 - Is sufficiently stable at the time of admission to the IRF to be able to actively participate in an intensive rehabilitation program.
 - Requires physician supervision by a rehabilitation physician ...or other licensed treating physician with specialized training and experience in inpatient rehabilitation. Generally, the requirement for medical supervision means that the rehabilitation physician must conduct **face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process.**

- **Inpatient Rehabilitation Facility Admission Requirements (continued):**

- Detailed reasoning behind why the patient is expected to meet the admission requirements is documented on the pre-admission screening.
- The reasoning is supported in the post-admission assessment and in the overall plan of care.

- **3-10 day assessment:**

- Eliminated the 3-10 evaluation because stays average 13 days, so it is no longer appropriate to allow 10 days to assess the patient.
- If the rehab physician's expectation prior to admission is not realized, the IRF can make arrangements to transfer the patient to another level of care.
- Any changes in the patient's status before and after admission need to be well-documented in the record.

- **Post-Admission Requirements:**

- Post-Admission Evaluation.

- The facility must have and utilize a post-admission evaluation process in which a rehabilitation physician completes a post-admission evaluation for each patient within 24 hours of that patient's admission to the IRF facility in order to document the patient's status on admission to the IRF, compare it to that noted in the preadmission screening individualized plan of care.
- This post-admission physician evaluation is to be retained in the patient's medical record.

- **Post-admission assessment:**

- Goes beyond information typically found in the H&P.
- Intended to provide:
 - Medical history
 - Validate the patient's condition on admission
 - Information on whether or not it is safe to initiate the patient's therapy program
 - Support for the medical necessity of the admission.
- Must be completed by a rehab physician in conjunction with a hands-on evaluation of the patient
 - May not be completed by a licensed independent practitioner.

- **Final Rule Example:**

- It would be useful for the post-admission assessment physician evaluation to:
 - Describe the clinical rehabilitation complications for which the patient is at risk and the specific plan to avoid them.
 - Describe the adverse medical conditions that might be created due to the patient's comorbidities and the rigours of the intensive rehab program, and the methods that might be used to avoid them.
 - Predict the functional goals to be achieved within the medical limitations of the patient.
 - Be a combined medical and functional resource for all team members in the care of the patient as they prepare to contribute to the individualized plan of care.
 - Document changes in the patient's status from that assessed at pre-admission.

- **Opportunities for improvement –**

- Stop confusion over what the physician extender can do and what the rehab physician must do
- Be sure the PAA includes a medical and functional preliminary plan of care
- Understanding what concurrence between status at pre-admission versus admission means

- **Individualized plan of care:**

- Individualized Overall Plan of Care. The facility shall ensure that:

- An individualized overall plan of care is developed by a rehabilitation physician with input from the interdisciplinary team within 96 hours of the patient's admission to the IRF.
- The individualized overall plan of care is retained in the patient's medical record.

- **Opportunities for Improvement –**

- COMPLETE BY THE END OF THE 4TH REHAB DAY
- Include a summary of team member's goals or refer to the goals to indicate agreement
- Include a summary of interventions or refer to the team interventions to indicate agreement
- Include the frequency and duration of each therapy discipline
- Be sure that the duration indicates at least 3 hours of therapy per day

- **Intensity of services:**

- The three-hour rule is generally the way that the intensity of therapy services proven.
 - 3 hours of therapy at least 5 days per week
- CMS stated that they did not intend for that to be the only way to prove intensity.
- Example was given to show when 15 hours of therapy in a week is appropriate for proving intensity.
- Also stated that this should be periodic and well documented that it is expected to benefit the patient.

- **Opportunities for Improvement –**

- No physician order for 15 hours over 7 days when that is appropriate
- Poor documentation of variances for missed time
- Missed time without recognition that time was missed (no variances)
- Notes do not indicate progress or need for intensive rehabilitation program

- **Interdisciplinary Team.**

- The facility shall ensure that each patient's treatment is managed using a coordinated interdisciplinary team approach to treatment.
 - At a minimum, the interdisciplinary team is to be led by a rehabilitation physician
 - And further consist of a registered nurse with specialized training or experience in rehabilitation
 - A social worker or case manager (or both)
 - A licensed or certified therapist from **each therapy discipline** involved in treating the patient.
 - All team members must have current knowledge of the patient's medical and functional status.

- **Interdisciplinary Team:**

- The team must meet at least once per week throughout the duration of the patient's stay to:
 - Implement appropriate treatment services
 - Review the patient's progress toward stated rehabilitation goals
 - Identify any problems that could impede progress towards those goals
 - Where necessary, reassess previously established goals in light of impediments
 - Revise the treatment plan in light of new goals
 - Monitor continued progress toward those goals.
- The rehabilitation physician must document concurrence with all decisions made by the interdisciplinary team at each team meeting.
- Physician makes final decision about patient's care and documents such.

- **Opportunities for Improvement –**

- RN, PT, OT, or ST not present
- Therapy assistants present without PT, OT, or ST
- No mention of plan of care
- Goals are not updated
- Not completed within the first week and every week thereafter

- **Director of Rehabilitation.**

- The IRF must have a director of rehabilitation who-
 - In a rehabilitation hospital provides services to the hospital and its inpatients on a full-time basis, or
 - In a rehabilitation unit, provides services to the unit and to its inpatients for at least 20 hours per week; and
 - Meets the definition of a physician as set forth in Section 1861(r) of the Act; and
 - Has had, after completing a one-year hospital internship, at least two years of training or experience in the medical management of inpatients requiring rehabilitation services.

- **Director of Rehabilitation:**

- While multiple specialists may be involved in a patient's care, the rehab physician is responsible for coordinating the medical needs with the functional needs.
- Assess the patient 3 times per week face-to-face to determine their medical and functional needs and modify the plan of care.
- This is a minimum standard.

- **Opportunities for Improvement –**

- When the physician extender documents daily visits, the rehab physician must add documentation at least three times per week
- Notes should include mention of functional status or progress at least three times per week

- **Group Therapy**

- CMS is wants to develop a definition of group therapy for IRFs and is seeking comments. Note that in the following narrative, CMS does not appear to define group therapy. CMS currently defines group therapy in the SNF and outpatient settings but does not reference either here. CMS stated: "we have heard that some IRFs are providing essentially all "group therapy" to their patients. We believe that group therapies have a role in patient care in an IRF, but that they should be used in IRFs primarily as an adjunct to one-on-one therapy services, not as the main or only source of therapy services provided to IRF patients. While we recognize the value of group therapy, we believe that group therapy is typically a lower intensity service that should be considered as a supplement to the intensive individual therapy services generally provided in an IRF. To improve our understanding of when group therapy may be appropriate in IRFs, we specifically solicit comments on the types of patients for which group therapy may be appropriate, and the specific amounts of group instead of one-on-one therapies that may be beneficial for these types of patients. We anticipate using this information to assess the appropriate use of group therapies in IRFs and may create standards for group therapies in IRFs."

- **Group Therapy**
 - No decisions made.
 - CMS will continue to evaluate and inform the field of decisions through proper means at a later date.

- **60% Rule Calculation:**

- Defined presumptive methodology
 - Utilize the data in the Medicare database to assess compliance based on the IGC and ICD-9 codes reported.
 - For a facility to be evaluated presumptively, at least 50% of their patients had to be Medicare recipients.
- Defined medical review methodology
 - Can be used at the fiscal intermediary's discretion.
 - Must be used when the facility's Medicare population was less than 50% of the total.

- **60% Rule Calculation:**

- With the increase in Medicare Advantage subscribers, facilities had difficulty meeting the 50% threshold.
- CMS is allowing facilities to submit MA IRF-PAIs to be included in the calculation for presumptive compliance.
- If the IRF fails to submit all MA IRF-PAIs, CMS would not count any MA cases in the presumptive compliance percentage.
- Removed the option to not submit IRF-PAIs on patients that the facility was not seeking payment for.
- ALL Medicare and MA IRF-PAIs must be submitted.

- **60% Rule Calculation:**

- IRF-PAI record retention 5 years for Medicare patients.
- IRF-PAI record retention 10 years for Medicare Advantage patients.
- This maintains consistency with data specifications in §412.504(d) and §412.504(f).

- **60% Rule Calculation:**

- Must provide the patient's Medicare number on all IRF-PAIs submitted.
- Allows CMS to verify the claims with the IRF-PAIs for MA patients.
- This number is available for all MA patients and it should be provided to the IRF by the MA organization when the patient is admitted.

- **60% Rule Calculation:**

- Must submit MA IRF-PAIs according the same transmission time line as other Medicare claims.
- Late transmissions preclude the facility from counting MA patients in the percentage for presumptive calculation except in extraordinary circumstances.
- Applies to discharges on or after 10/1/09.



erehabdata.com

Questions?

Contact Information

Lisa Werner, MBA, MS, CCC-SLP

Lwerner@erehabdata.com

(202) 588-1766

Better outcomes for everyone.