Medical Coverage Policy | Acute Inpatient Rehabilitation Level of Care

EFFECTIVE DATE: 03|15|2025
POLICY LAST REVIEWED: 07|02|2025

OVERVIEW

This policy is to document the criteria for coverage of services at the acute inpatient rehabilitation level of care.

MEDICAL CRITERIA

In order for Inpatient Rehabilitation Facilities (IRF) care to be considered reasonable and necessary, the documentation in the patient's IRF preadmission screening medical record must include an evaluation of the patient's risk for clinical complications, indication of the patient's prior level of function, expected level of improvement and the expected length of time necessary to achieve that level of improvement AND the following (1 – 5):

1. The active and ongoing therapeutic intervention of multiple therapy disciplines (one of which must be physical or occupational therapy):
    - **a.** Occupational therapy, or
    - **b.** Physical therapy, or
    - **c.** Speech language pathology, or
    - **d.** Prosthetics or Orthotics
2. An intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least:
    - **a.** 3 hours of therapy per day, and
    - **b.** 5 days per week.

    In certain well documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive calendar day period, beginning with the date of admission to the IRF.
3. The patient must reasonably be expected to actively participate in intensive rehabilitation therapy at the time of admission. The patient should be expected to benefit significantly from the intensive rehabilitation therapy program as a result of the treatment and improvement should be expected to be made within a prescribed period of time.
4. The patient is required to receive physician supervision by a rehabilitation physician, defined as a licensed physician who is determined by the IRF to have specialized training and experience in inpatient rehabilitation. Medical supervision by the physician must include at least 3 days per week of face-to-face visits throughout the patient's stay 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. Beginning with the second week of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may conduct 1of the 3 required face-to-face visits with the patient per week, provided that such duties are within the non-physician practitioner's scope of practice under applicable state law. In the first week of the patient's IRF stay, the rehabilitation physician is required to visit the patients a minimum of three times to ensure that the patient's plan of care is fully established and optimized to the patient's care needs in the IRF. For the second, third, fourth weeks of the stay, and beyond, CMS will continue to require the patient in the IRFs to receive a minimum of three rehabilitation physician visits per week, but will allow non-physician practitioners to independently conduct one of these three minimum require visits per week.
5. The patient must require an intensive and coordinated interdisciplinary approach to providing rehabilitation.

The decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including but not limited to the patient's medical history and current medical needs, the types of facilities available, etc.

An IRF stay will only be considered reasonable and necessary if at the time of admission to the IRF the documentation in the patient's IRF medical record indicates a reasonable expectation that the complexity of the patient's nursing, medical management, and rehabilitation needs requires an inpatient stay **and** an interdisciplinary team approach to the delivery of rehabilitation care. That is, the complexity of the patient's condition must be such that the rehabilitation goals indicated in the preadmission screening, and the overall plan of care can only be achieved through periodic team conferences—at least once a week—of an interdisciplinary team of medical professionals (as defined below).

Interdisciplinary services are those provided by a treatment team in which all of its members participate in a coordinated effort to benefit the patient and the patient's significant others and caregivers. Interdisciplinary services, by definition, cannot be provided by only one discipline. Though individual members of the interdisciplinary team work within their own scopes of practice, each professional is also expected to coordinate his or her efforts with team members of other specialties, as well as with the patient and the patient's significant others and caregivers. The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals.

PRIOR AUTHORIZATION

Prior authorization is required for Medicare Advantage Plans and recommended for Commercial Products.

Medicare Advantage Plans

Effective March 15, 2025, a post-acute care vendor has been delegated to perform utilization management services for admission, concurrent, and retrospective requests according to this policy, except for members who are attributed to a Prospect Primary Care Provider.

POLICY STATEMENT

Medicare Advantage Plans and Commercial Products

Acute inpatient rehabilitation is covered for all Blue Cross & Blue Shield of Rhode Island (BCBSRI) products when the medical criteria are met.

Medicare may change coverage or criteria. All changes are effective when Medicare determines them to be so and are applicable to Medicare Advantage Plan members and will supersede this policy.

COVERAGE

Benefits may vary between groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage, or Subscriber Agreement for applicable Inpatient Rehabilitation coverage/benefits.

BACKGROUND

Acute Inpatient Rehabilitation Requirements

1. Preadmission Screening

A preadmission screening is an evaluation of the patient's condition and need for rehabilitation therapy and medical treatment that must be conducted by licensed or certified clinician(s) within the 48 hours immediately preceding the IRF admission. A preadmission screening that includes all of the required elements, but that is conducted more than 48 hours immediately preceding the IRF admission, will be accepted as long as an update is conducted in person or by telephone to document the patient's medical and functional status within the 48 hours immediately preceding the IRF admission in the patient's medical record at the IRF. The preadmission screening in the patient's IRF medical record serves as the primary documentation by the IRF clinical staff of the patient's status prior to admission and of the specific reasons that led the IRF clinical staff to conclude that the IRF admission would be reasonable and necessary. As such, IRFs must make this documentation detailed and comprehensive.

The preadmission screening documentation must indicate the patient's:

- Prior level of function (prior to the event or condition that led to the patient's need for intensive rehabilitation therapy),
- Expected level of improvement,
- Expected length of time necessary to achieve that level of improvement,
- Evaluation of risk for clinical complications,
- Conditions that caused the need for rehabilitation,
- Treatments needed (i.e., physical therapy, occupational therapy, speech language pathology, or prosthetics/orthotics),
- Anticipated discharge destination.

If the patient is being transferred from a referring hospital, the preadmission screening could either be done in person or through a review of the patient's medical records from the referring hospital (either paper or electronic format), as long as those medical records contain the necessary assessments to make a reasonable determination. However, a preadmission screening conducted entirely by telephone should generally include transmission of the patient's medical records from the referring hospital to the IRF and a review of those records by licensed or certified clinical staff member in the IRF to ensure it includes a detailed and comprehensive review of the patient's condition and medical history.

2. Overall Plan of Care

The information from the preadmission screening and other information garnered from the assessments of all therapy disciplines involved in treating the patient and other pertinent clinicians, must be synthesized by a rehabilitation physician to support a documented overall plan of care. The overall plan of care should generally detail the patient's medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRF stay, thereby supporting the medical necessity of the admission.

The anticipated interventions detailed in the overall plan of care should generally include the:

a. Expected intensity (number of hours per day),
b. Frequency (number of days per week), and
c. Duration (total number of expected IRF days) of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies required by the patient during the IRF stay.

Note: The expected patient's course of treatment should generally be based on the patient's impairments, functional status, complicating conditions, and any other contributing factors.

Whereas the individual assessments of appropriate clinical staff will contribute to the information contained in the overall plan of care, the rehabilitation physician is responsible for developing the overall plan of care with input from the interdisciplinary team.

In order for the IRF admission to be considered reasonable and necessary, the overall plan of care must be completed within the first 4 days of the IRF admission. The plan of care must support the determination that the IRF admission is reasonable and necessary, and it must be retained in the patient's medical record at the IRF.

3. Required Admission Orders

At the time that each patient is admitted to an IRF, a physician must generate admission orders for the patient's care. These admission orders should generally be retained in the patient's medical record at the IRF.

4. Required Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)

The IRF patient assessment instrument (IRF-PAI) forms should generally be included in the patient's medical record at the IRF (either in electronic or paper format).

5. Multiple Therapy Disciplines

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. For this reason, the information in the patient's IRF medical record must document a reasonable expectation that, at the time of admission to the IRF, the patient required the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy.

6. Intensive Level of Rehabilitation Services

A primary distinction between the IRF environment and other rehabilitation settings is the intensity of rehabilitation therapy services provided in an IRF. For this reason, the information in the patient's IRF medical record must document a reasonable expectation that at the time of admission to the IRF the patient generally required the intensive rehabilitation therapy services that are uniquely provided in IRFs. 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 that such intensity of services can be demonstrated (that is, CMS does not intend for this measure to be used as a "rule of thumb" for determining whether a particular IRF claim is reasonable and necessary).

The intensity of therapy services provided in IRFs could also be demonstrated by the provision of 15 hours of therapy per week (that is, in a 7-consecutive calendar day period starting from the date of admission). 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. Thus, IRFs may also demonstrate a patient's need for intensive rehabilitation therapy services by showing that the patient required and could reasonably be expected to benefit from at least 15 hours of therapy per week (defined as a 7-consecutve calendar day period starting from the date of admission), as long as the reasons for the patient's need for this program of intensive rehabilitation are well-documented in the patient's IRF medical record and the overall amount of therapy can reasonably be expected to benefit the patient. Many IRF patients will medically benefit from more than 3 hours of therapy per day or more than 15 hours of therapy per week, when all types of therapy are considered. However, the intensity of therapy provided must be reasonable and necessary and must never exceed the patient's level of need or tolerance, or compromise the patient's safety. See below for a brief exceptions policy for temporary and unexpected events.

The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF. Therapy evaluations are generally considered to constitute the beginning of the required therapy services. As such, they should generally be included in the total daily/weekly provision of therapies used to demonstrate the intensity of therapy services provided in an IRF.

The standard of care for IRF patients is individualized (i.e., one-on-one) therapy. Group therapies serve as an adjunct to individual therapies. In those instances in which group therapy better meets the patient's needs on a limited basis, the situation/rationale that justifies group therapy should be specified in the patient's medical record at the IRF

Brief Exceptions: 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 should generally 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) should generally not affect the determination of the medical necessity of the IRF admission. Thus, brief exceptions to the intensity of therapy requirement maybe considered for approval 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, postadmission physician evaluation, and overall plan of care that were based on reasonable conclusions.

7. Ability to Actively Participate in Intensive Rehabilitation Therapy Program
The information in the patient's IRF medical record must document a reasonable expectation that at the time of admission to the IRF the patient's condition is such that the patient can reasonably be expected to actively participate in, and significantly benefit from, the intensive rehabilitation therapy program.

8. Physician Supervision
A primary distinction between the IRF environment and other rehabilitation settings is the high level of physician supervision that accompanies the provision of intensive rehabilitation therapy services. For this reason, the information in the patient's IRF medical record must document a reasonable expectation that at the time of admission to the IRF the patient's medical management and rehabilitation needs require an inpatient stay and close physician involvement. Close physician involvement in the patient's care is demonstrated by documented face-to-face visits from a rehabilitation physician at least 3 days per week throughout the patient's IRF stay. Beginning with the second week of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may conduct 1 of the 3 required face-to-face visits with the patient per week, provided that such duties are within the non-physician practitioner's scope of practice under applicable state law. In the first week of the patient's IRF stay, the rehabilitation physician is required to visit patients a minimum of three times to ensure that the patient's plan of care is fully established and optimized to the patient's care needs in the IRF. In the second, third, fourth weeks of the stay, and beyond, CMS will continue to require patients in IRFs to receive a minimum of three rehabilitation physician visits per week, but will allow non-physician practitioners to independently conduct one of these three minimum required visits per week.

The purpose of the face-to-face visits is to assess the patient both medically and functionally (with an emphasis on the important interactions between the patient's medical and functional goals and progress), as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. Other physician specialties may treat and visit the patient, as needed, more often than 3 days per week. However, the requirement for IRF physician supervision is intended 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 who is determined by the IRF to have specialized training and experience in inpatient rehabilitation at least 3 times per week. The required rehabilitation physician and non-physician practitioner visits should generally be documented in the patient's medical record at the IRF.

9. Interdisciplinary Team Approach to the Delivery of Care
An IRF stay will only be considered reasonable and necessary if at the time of admission a reasonable expectation that the complexity of the patient's nursing, medical management, and rehabilitation needs requires an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care. That is, the complexity of the patient's condition must be such that the rehabilitation goals indicated in the preadmission screening, and the overall plan of care can only be achieved through periodic team conferences—at least once a week—of an interdisciplinary team of medical professionals.

Interdisciplinary services are those provided by a treatment team in which all of its members participate in a coordinated effort to benefit the patient and the patient's significant others and caregivers. Interdisciplinary services, by definition, cannot be provided by only one discipline. Though individual members of the interdisciplinary team work within their own scopes of practice, each professional is also expected to coordinate their efforts with team members of other specialties, as well as with the patient and the patient's significant others and caregivers. The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals.

At a minimum, the interdisciplinary team must document participation by professionals from each of the following disciplines (each of whom must have current knowledge of the patient as documented in the medical record at the IRF):

a. A rehabilitation physician who is determined by the IRF to have specialized training and experience in inpatient rehabilitation;
b. A registered nurse with specialized training or experience in rehabilitation;
c. A social worker or a case manager (or both); and
d. A licensed or certified therapist from each therapy discipline involved in treating the patient.

The interdisciplinary team must be led by a rehabilitation physician either in person or remotely via a mode of communication such as video or telephone conferencing, who is responsible for making the final decisions regarding the patient's treatment in the IRF. This physician must document concurrence with all decisions made by the interdisciplinary team at each meeting.

The periodic team conferences—held a minimum of once per week—must focus on:

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

A team conference may be formal or informal; however, a review by the various team members of each other's notes does not constitute a team conference. It is expected that all treating professionals from the required disciplines will be at every meeting or, in the infrequent case of an absence, be represented by another person of the same discipline who has current knowledge of the patient. Documentation of each team conference should generally include the names and professional designations of the participants in the team conference. Signatures from participants of the interdisciplinary team meeting are not required other than the rehabilitation physician's concurrence as noted above. The occurrence of the team conferences and the decisions made during such conferences, such as those concerning discharge planning and the need for any adjustment in goals or in the prescribed treatment program, must be recorded in the patient's medical record in the IRF. The focus of the review of this requirement will be on the accuracy and quality of the information and decision-making, not on the internal processes used by the IRF in conducting the team conferences.

10. Definition of Measurable Improvement

A patient can only be expected to benefit significantly from an intensive rehabilitation therapy program provided in an IRF, if the patient's IRF medical record indicates a reasonable expectation that a measurable, practical improvement in the patient's functional condition can be accomplished within a predetermined and reasonable period of time. In general, the goal of IRF treatment is to enable the patient's safe return to the home or community-based environment upon discharge from the IRF. The patient's IRF medical record is expected to indicate both the nature and degree of expected improvement and the expected length of time to achieve the improvement.

CODING

Not applicable

RELATED POLICIES

None

PUBLISHED

Provider Update, January/September 2025
Provider Update, May, July 2024
Provider Update, May 2023
Provider Update, August 2022
Provider Update, December 2021

REFERENCES

1. Centers for Medicare and Medicaid Services, Medicare Benefit Policy Manual: Chapter 1 - Inpatient Hospital Services Covered Under Part A; Section 110 - Inpatient Rehabilitation Facility (IRF) Services. Medicare Benefit Policy Manual (cms.gov)
2. Centers for Medicare & Medicaid Services, Medicare Learning Network. Inpatient Rehabilitation Facility (IRF) Medical Review Changes, MLN Matters Number: SE17036 Revised.
3. Centers for Medicare & Medicaid Services, Medicare Learning Network. Internet Only Manual Updates to Publication (Pub.) 100-02 to Implement Updates to Policy and Correct Errors and Omissions (Inpatient Rehabilitation Facility (IRF)), MLN Matters Number: MM12353