

**EFFECTIVE DATE:** 07|06|2010

**POLICY LAST UPDATED:** 09|17|2019

## OVERVIEW

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

## MEDICAL CRITERIA

An inpatient rehabilitation facility (IRF) is designed to provide intensive rehabilitation therapy in a resource-intensive inpatient hospital environment for patients who have complex nursing, medical management, and rehabilitation needs. These patients:

1. Can reasonably be expected to actively participate in, and will significantly benefit from an inpatient stay and the intensity is such that the patient's condition requires this level of care; and
2. Require an interdisciplinary team approach to the delivery of rehabilitation care; and
3. Have complex unstable medical problems and require the services of a physician.

In order for IRF care to be considered reasonable and necessary, the documentation in the patient's IRF preadmission screening medical record must include the following:

1. An evaluation of the patient's risk for clinical complications.
2. 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
3. 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 day period, beginning with the date of admission to the IRF.

The clinical review judgment to determine medical necessity of the intensive rehabilitation therapy program will be based on the individual facts and circumstances of the case and not on the basis of any threshold of therapy time.

4. 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.
5. The patient is required to receive physician supervision by a rehabilitation physician, defined as a licensed physician with 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.
6. The patient must require an intensive and coordinated interdisciplinary approach to providing rehabilitation.

Concurrent care requires the following (at this time we do not conduct concurrent care reviews but we may do so in the future):

- a. Post-admission physician evaluation, and
- b. Overall plan of care, and
- c. Admission orders that must demonstrate a reasonable expectation that the criteria above were met at the time of admission to the IRF

The primary distinction between the IRF environment and other rehabilitation settings is the high level of physician supervision that accompanies the participation in intensive rehabilitation therapy services. An IRF stay may be considered medically necessary for patients with complex unstable medical problems such as those requiring the medical supervision of a physician. Patients who meet the acute level of care criteria for an IRF have medically complex conditions and often require services such as medication adjustments, timely intervention of IV medication, recognition of acute deterioration necessitating acute hospital transfer, pulmonary rehabilitation and emergency lifesaving medical and surgical procedures. Patients admitted to inpatient facilities frequently suffer from comorbidities in addition to the primary diagnosis. An IRF stay would not be considered covered if the patient's condition is such that it would be appropriate to receive medically necessary services in a less intensive setting, such as a skilled nursing facility (SNF) or an outpatient facility.

Example: The following patient characteristics have been identified that add complexity in a way that is likely to require an IRF level of care:

- Knee or hip joint replacement, or both, during an acute care hospitalization immediately preceding the inpatient rehabilitation stay and also meets one or more of the following specific criteria:
  - The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute care hospital admission immediately preceding the IRF admission;
  - The patient is extremely obese with a body mass index (BMI) of at least 50 at the time of admission to the IRF; or
  - The patient is age 85 or older at the time of admission to the IRF.

## **PRIOR AUTHORIZATION**

Preauthorization is required for BlueCHiP for Medicare and recommended for Commercial products.

## **POLICY STATEMENT**

### **BlueCHiP for Medicare and Commercial Products**

Acute inpatient rehabilitation is covered for all 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 BlueCHiP for Medicare 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 inpatient 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 admission in the patient's medical record at the inpatient rehabilitation facility.

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, and 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),
- Expected frequency and duration of treatment in the inpatient rehabilitation,
- Anticipated discharge destination,
- Any anticipated post-discharge treatments, and
- Other information relevant to the care needs of the patient.

A preadmission screening conducted entirely by telephone will not be accepted without transmission of the patient's medical records from the referring hospital to the inpatient rehabilitation facility and a review of those records by licensed or certified clinical staff in the rehabilitation facility.

It is the IRF's responsibility for developing a thorough preadmission screening process for patients admitted to a rehabilitation facility from home or a community-based environment. However, such admissions may not necessarily involve the use of medical records from a prior hospital stay in another inpatient hospital setting unless such records are pertinent to the individual patient's situation.

"Trial" IRF admissions, during which patients are sometimes admitted for 3 to 10 days to assess whether the patients would benefit significantly from treatment in the IRF or other settings, are no longer considered reasonable and necessary. Such determination must be made through a careful preadmission screening prior to the patient's admission to the IRF.

## 2. Overall Plan of Care

The overall plan of care and estimated length of stay is decided by using the combined information garnered from the preadmission screening and the post-admission physician evaluation, together with other information gathered from all therapy discipline assessments involved in treating the patient, and other related clinicians. The overall plan of care is determined by the rehabilitation physician and must detail the patient's medical prognosis and 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 must 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 must be based on the patient's impairments, functional status, complicating conditions, and any other contributing factors.

In event that the patient's actual length of stay and/or the expected intensity, frequency, and duration of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies differ significantly from

the expectations indicated in the overall plan of care, then the reasons for the discrepancies must be documented in detail in the patient's medical record.

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. Admission Orders**

Admission orders for the patient's care must be generated by a physician at the time the patient is admitted to an IRF and documentation must be retained in the patient's medical record.

### **4. Inpatient Rehabilitation Facility Patient Assessment**

IRF patient assessment instrument (IRF-PAI) forms must be included in the patient's medical record (either in electronic or paper format). The information in the IRF-PAIs must correspond with all of the information provided in the patient's IRF medical record.

### **5. Multiple Therapy Disciplines**

At the time of admission, information that the patient required the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, or occupational therapy, speech-language pathology, or prosthetics/orthotics), must be documented in the patient's medical record.

### **6. Intensive Level of Rehabilitation Services**

The accepted standard by which the intensity of rehabilitation services is measured is typically 15 hours a week, for at least 3 hours per day for at least 5 days per week, or 7 consecutive days starting from the date of admission. However, some 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. 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.

**Example:** If a patient was admitted for a hip fracture, but was also undergoing chemotherapy, the patient might not be able to tolerate therapy on a predictable basis due to the chemotherapy. Thus, the patient might be more effectively served by receiving 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 their chemotherapy schedule. The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF. Therapy evaluations establish the beginning of the required therapy services. As such, they are included in the total daily/weekly provision of therapies used to demonstrate the intensity of therapy services provided. 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.

**Exceptions:** As the patient's needs vary over time, if an unexpected clinical event occurs during the course of the stay that limits the ability of the patient to participate in therapy 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 therapy services must be documented in the patient's IRF medical record.

The break in service will not affect the determination of medical necessity of the IRF admission. Thus, brief exceptions to the intensity of therapy requirement may be allowed in these cases if it is determined that the initial expectation of the patient's active participation in intensive therapy during the stay was based on a

diligent preadmission screening, post-admission 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 participation in 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 or other licensed treating physician with specialized training and experience in rehabilitation at least 3 days per week throughout the patient's IRF stay. The purpose of the face-to-face visits is to assess the patient both medically and functionally (with the emphasis on the important interactions between the patient's medical and functional goals and progress).

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 with the necessary training and experience to make these assessments at least 3 times per week. The required rehabilitation physician visits must 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, the post admission physician evaluation, 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 with specialized training and experience in rehabilitation services;
- 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 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 must include the names and professional designations of the participants in the team conference. 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**

Documentation in the patient's medical record is expected to provide evidence to demonstrate that improvement in the patient's functional condition was accomplished within a predetermined (and reasonable) length of time. The goal of inpatient treatment is to enable the patient's safe return to home or community based environment when discharge from the IRF.

#### **11. Required Post-Admission Physician Evaluation**

The purpose of the post-admission physician evaluation is to 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 that will be completed with input from all of the interdisciplinary team members in the overall plan of care. A dated, timed, and authenticated post-admission physician evaluation must be retained in the patient's IRF medical record. The post-admission physician evaluation must:

- Be performed by a rehabilitation physician and completed within the first 24 hours after admission to the IRF;
- Support medical necessity of admission;
- Identify any relevant changes that may have occurred since the preadmission screening; and
- Include a documented History and Physical (H&P) exam, as well as a review of prior and current medical and functional conditions and comorbidities.
  - A resident or physician extender (as defined in Section 1861(s)(2)(K) of the Social Security Act [SSA]) can complete the H&P component of the evaluation.
  - If a resident or physician extender completes the H&P, the rehabilitation physician must still visit the patient and complete the other required parts.

If the post-admission physician evaluation does not support the continued appropriateness of the IRF services for the patient, the IRF shall begin the discharge process immediately. Services after the 3rd day will not be considered reasonable and necessary, and the IRF will be paid at the appropriate payment rate for IRF patient stays of 3 days or less.



**NOTE:** The post-admission physician evaluation may **not** serve as one of the three required rehabilitation physician face-to-face visits in the first week.

### **CODING**

Not applicable

### **RELATED POLICIES**

None

### **PUBLISHED**

Provider Update, November 2019  
Provider Update, Nov. /Dec. 2018  
Provider Update, October 2017  
Provider Update, November 2016  
Provider Update December 2015  
Provider Update, November 2014  
Provider Update, August 2013

### **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.
2. Centers for Medicare & Medicaid Services, Department Of Health And Human Services. Title 42--Public Health Chapter IV-- Part 412--Prospective Payment Systems For Inpatient Hospital Services § 412.23  
*Excluded hospitals: Classifications.*
3. DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services Medicare Learning Network Inpatient Rehabilitation Facility Prospective Payment System ICN 006847 November 2013:  
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/InpatRehabPaymtfctsht09-508.pdf>
4. DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services Medicare Learning Network Inpatient Rehabilitation Therapy Services: Complying with Documentation Requirements ICN 905643 July 2012  
[http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Inpatient\\_Rehab\\_Fact\\_Sheet\\_ICN905643.pdf](http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Inpatient_Rehab_Fact_Sheet_ICN905643.pdf)

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