APPENDIX B

LCD for Inpatient Rehabilitation Services Provided in an Inpatient Rehabilitation Facility (IRF) (L25714)

Contractor Information

Contractor Name

National Government Services, Inc.

Contractor Number

Number	Type	State(s)
00130	FI	IN
00131	FI	IL
00160	FI	KY
00180	FI	ME
00181	FI	MA
00270	FI	NH, VT
00308	FI	CT, DE, NY
00332	FI	OH
00450	FI	WI
00452	FI	MI
00453	FI	VA, WV
00454	FI	AS, CA, CNMI, GU, HI, NV
00630	Carrier	IN
00660	Carrier	KY
00803	Carrier	NY (Downstate, except Queens County)
00805	Carrier	NJ

Contractor Type

Carrier

FI

LCD Information

LCD ID Number

L25714

LCD Title

Inpatient Rehabilitation Services Provided in an Inpatient Rehabilitation Facility (IRF)

Contractor's Determination Number

L25714 - Cor#1

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CMS National Coverage Policy

Language quoted from CMS National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the LCD Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, *italicized* text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act (SSA):

Section 1862(a)(1)(A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1833(a)(8)(B)(i) of Title XVIII of the Social Security Act allows payment for ancillary services and therapies when Part A coverage is not made

Section 1833(e) of Title XVIII of the Social Security Act prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Section 1861(v)(1)(G) of Title XVIII of the Social Security Act allows payment at an average skilled nursing facility (SNF) rate when inpatient hospital care is not medically necessary but no post-hospital care beds are available

Section 1886(j) of Title XVIII of the Social Security Act describes the prospective payment system (PPS) for inpatient rehabilitation services.

Code of Federal Regulations:

42 CFR Section 412.23 defines criteria that must be met for facilities to be considered inpatient rehabilitation facilities (IRFs).

42 CFR Section 412.25 defines criteria for a rehabilitation unit, including satellite facilities, to be excluded from the acute care PPS.

42 CFR Section 412.29 defines additional criteria for rehabilitation units, including patient selection, plan of treatment, and need for multidisciplinary team services.

42 CFR Section 412.604 specifies conditions for payment under the prospective payment system for IRFs, including the requirement to complete the Patient Assessment Instrument.

66 FR 41316, August 7, 2001 established the IRF PPS.

CMS Publications:

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, sections 110.1 through 110.5 defines coverage guidelines for Inpatient Rehabilitation Facility stays.

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 140.3 describes proper use of revenue codes in an IRF.

CMS Program Memorandum, Transmittal No. A-01-110, Change Request # 1851, September 14, 2001 contains instructions for the implementation of IRF-PPS.

Primary Geographic Jurisdiction

Number	Type	State(s)
00130	FI	IN
00131	FI	IL
00160	FI	KY
00180	FI	ME
00181	FI	MA
00270	FI	NH, VT
00308	FI	CT, DE, NY
00332	FI	OH
00450	FI	WI
00452	FI	MI
00453	FI	VA, WV
00454	FI	AS, CA, CNMI, GU, HI, NV
00630	Carrier	IN
00660	Carrier	KY
00803	Carrier	NY (Downstate, except Queens County)
00805	Carrier	NJ

Oversight Region

Region I, II, III, V, IX

Original Determination Effective Date
For services performed on or after 12/01/2007
Original Determination Ending Date
Not applicable
Revision Effective Date
For services performed on or after 12/01/2007
Revision Ending Date
Not applicable
Indications and Limitations of Coverage and/or Medical Necessity
1. **Abstract:**

This Local Coverage Determination (LCD) addresses Medicare coverage for rehabilitation services provided in an Inpatient Rehabilitation Facility (IRF), whether free-standing or an "excluded" unit [as defined in 42 CFR, Section 412.25]. The medical necessity for provision of the rehabilitative services in an inpatient setting is the primary focus. We note a distinction between medical necessity for individual therapy services, which may be reasonable and necessary in a particular case, and the medical necessity of providing coordinated, comprehensive and interdisciplinary services in an inpatient rehabilitation setting. This LCD describes the relevant factors that differentiate Medicare coverage for rehabilitation in an IRF from coverage for rehabilitation in other settings, such as acute care hospitals, skilled nursing facilities (SNFs), home health care, and outpatient settings.

Much of the language in this LCD is taken directly from the Center for Medicare and Medicaid Services' (CMS') online manual, Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110 et seq. which replaces information formerly found in the CMS Hospital Manual, section 211.

Rehabilitation medicine is philosophically grounded in a biopsychosocial understanding of health as a functional concept, as opposed to a disease concept. For instance, when an individual survives an acute event with some sort of residual impairment(s) and/or experiences the bodily deterioration that comes with aging, such conditions often cannot be "cured", but their negative impact on the individual's life can be ameliorated through the application of rehabilitation principles. *The International Classification of Functioning, Disability and Health (ICF)*, developed by the World Health Organization (WHO) provides a useful structure for thinking about rehabilitation medicine. The *ICF* is based on the premise that health outcomes can be measured in several domains – disease (will the treatment cure the pathology?), impairment (will the treatment eliminate or decrease problems in the structure or function of a particular body part or system?), disability (will the treatment increase the person's ability to perform activities of daily living (ADLs) despite impairments in body structure or function?) and handicap (will the person be

able to perform his or her normal role in society despite some degree of disability?). This LCD will focus on those aspects of rehabilitation that are most appropriately rendered in an inpatient setting.

There have been relatively few well-controlled research studies measuring the effectiveness of intensive inpatient rehabilitation in comparison with other methods of delivering rehabilitation services to patients in the United States. [25, 15, 21, 19] A significant problem in conducting such research is that a particular patient's need for rehabilitative services is multi-factorial and doesn't correlate well with a simple unitary measurement such as diagnosis. [14, 15, 37] A given diagnosis such as stroke can result in a wide range of impairments which, in turn, cause varying levels of disability and/or handicap depending on their interaction with multiple additional factors such as pre-morbid functional level, medical acuity, mental or psychological status, co-morbid conditions, available social support, and environmental barriers within an individual's living situation. [11, 31, 37]

This complexity has led to the development of multiple instruments designed to predict the relationship between a patient's functional deficits and optimal resource use but, unfortunately, the various settings (IRF, SNF, home health, etc.) where rehabilitation services are offered use different patient classification tools. When researchers compare these instruments, they find substantial variation in their content and in how items are defined and scored, making comparisons across settings difficult. An effort to devise a common instrument for use in all of the various post-acute settings has so far failed to produce a standardized product. [2, 20, 21]

Such problems do not mean, however, that there is no way to determine circumstances in which intensive inpatient rehabilitation is appropriate. For instance, there is literature describing other types of studies, research conducted in other countries (keeping in mind differences in health care system structure) and studies looking at specific factors (e.g. early transfer to rehabilitation), all of which can provide guidance in selecting those elements of intensive inpatient rehabilitation that differentiate it from other rehabilitation settings. [11, 27, 15] There is also a wealth of material in chapter 1, section 110 et seq., of CMS publication 100-02, the *Medicare Benefit Policy Manual*. This material was developed many years ago with considerable input from rehabilitation professionals and, while some particulars are outdated, it still provides an excellent foundation on which to base this LCD.

2. **Indications:**

Since the need for inpatient rehabilitation is more dependent on the effects of

a patient's injury or illness (impairments, functional deficits, achievable goals) than on the precipitating cause (diagnosis), we have not included a finite listing of diagnoses appropriate for inpatient rehabilitation in this LCD. This is not meant to imply that all diagnoses are similarly weighted in terms of medical necessity – a relatively uncomplicated condition such as post-operative rehabilitation following a unilateral knee replacement will likely require very careful attention to documentation to support intensive inpatient rehabilitation, whereas a patient admitted for rehabilitation following a new traumatic spinal cord injury with paraplegia (e.g. T10 ASIA A level of injury) will be a more obvious candidate.

Evaluation of appropriateness for IRF admission

Pre-admission screening (before the patient is admitted to the IRF)

Before a patient is admitted to a rehabilitation hospital for treatment, a preadmission screening is normally done. This screening is a preliminary review of the patient's condition and previous medical record to determine if the patient is likely to benefit significantly from an intensive hospital program or extensive inpatient assessment.

While preadmission screening is a standard practice in most rehabilitation hospitals and may provide useful information for claims review purposes, the absence of preadmission screening in a particular case is not adequate reason for denying a claim. However, in a case where an inpatient assessment showed that a patient clearly was not a good candidate for an inpatient hospital program, then the presence or absence of preadmission screening information is important in determining whether the inpatient assessment itself was reasonable and necessary. If preadmission screening information indicated that the patient had the potential for benefiting from an inpatient hospital program, a period of inpatient assessment could be covered, up to the point where it was determined that inpatient hospital rehabilitation was not appropriate, since preadmission screening cannot be expected to eliminate all unsuitable candidates. CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110.2

Hospitalization after the pre-admission screening is covered only in those cases where the pre-admission screening results in a conclusion by the rehabilitation team that a significant practical improvement can be expected in a reasonable period of time. CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110.4.6 See the "Documentation" section for more information on what is meant by "significant practical improvement".

Inpatient rehabilitation facilities should have in effect a preadmission screening procedure under which each prospective patient's condition and medical history are reviewed to determine whether the patient is likely to benefit significantly from an intensive inpatient hospital program or assessment. The screening of the patient's condition is done to determine the patient's rehabilitation needs and appropriateness of providing those rehabilitation needs in an IRF setting. It is recommended that pre-admission screening be completed as close to discharge from the site where the screening is performed (typically an acute care hospital) in order to better assess the patient's condition concerning rehabilitation needs and potential. For example, performing a pre-admission screen of a patient on the first post-surgical day while the patient is still heavily medicated and in significant pain would not capture a true picture of the patient's rehabilitation needs to determine if the admission to the IRF is medically reasonable and necessary. Many post-surgical patients make significant functional gains in the first several days after the surgery while still in the acute care hospital.

Initial assessment (after the patient is admitted to the IRF)

Coverage is available for inpatient assessment of a patient's potential to benefit from an intensive coordinated rehabilitation program only if it was reasonable and necessary to perform the assessment in the hospital. This determination is made on the basis of information available in the patient's medical record. It is important to note that the assessment process is not merely a paperwork review, but rather an onsite professional review of the patient's condition by the necessary disciplines. CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110.3.1

An inpatient assessment may be covered even if the assessment subsequently indicates that a patient is not suitable for an intensive inpatient hospital rehabilitation program, if the patient's condition on admission was such that an extensive inpatient assessment was considered reasonable and necessary for a final decision to be made on a patient's actual rehabilitation potential. Where the initial assessment has resulted in a conclusion that the individual is a poor candidate for rehabilitation care, coverage for further inpatient hospital care is limited to a reasonable number of days needed to permit appropriate placement of the patient. CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110.3.1

The fact that an individual received therapy prior to admission to a

hospital for a rehabilitation program does not necessarily mean that the initial assessment period was not reasonable and necessary. However, if during a previous hospital stay an individual completed such a program for essentially the same condition for which inpatient hospital care is now being provided, the assessment period could be covered only if:

- *Some intervening circumstance rendered such an assessment reasonable and necessary; or*
- *The subsequent admission is to an institution utilizing techniques or technology not previously available or not available in the first institution.* CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110.3.1

Therapeutic rehabilitation services in an inpatient hospital setting

Patients needing rehabilitative services require a hospital level of care, if they need a relatively intense rehabilitation program that requires a multidisciplinary coordinated team approach to upgrade their ability to function. There are two basic requirements that must be met for inpatient hospital stays for rehabilitation care to be covered:

1. *The services must be reasonable and necessary (in terms of efficacy, duration, frequency, and amount) for the treatment of the patient's condition; and*

2. *It must be reasonable and necessary to furnish the care on an inpatient hospital basis, rather than in a less intensive facility such as a SNF, or on an outpatient basis.* CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110.1

Rehabilitative care in a hospital, rather than in a SNF or on an outpatient basis, is reasonable and necessary for a patient who requires a more coordinated, intensive program of multiple services than is generally found out of a hospital. A patient probably requires a hospital level of care if they have either one or more conditions requiring intensive and multi-disciplinary rehabilitation care, or a medical complication in addition to their primary condition, so that the continuing availability of a physician is required to ensure safe and effective treatment. CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110.4

More specifically, inpatient rehabilitation in a hospital setting will be considered medically reasonable and necessary if (a, b, c, and d are all required):

a. There is a reasonable expectation of measurable improvement that will be of practical value to the patient within a predictable and reasonable period of time, AND

b. The patient requires and can tolerate at least three hours per day of skilled therapy at least five times per week or, in the instance of a medical condition that limits participation, documentation that justifies the medical necessity and the appropriateness for IRF admission despite the lower level of therapy intensity.
(See Item #3 in the "Documentation" section for additional information), AND

c. The patient requires active and ongoing, multidisciplinary intervention acting in a coordinated fashion and based on the patient's needs. (See #4 in the "Documentation" section for additional information regarding the "minimum" IRF team members)

d. Factors that support the appropriateness of providing rehabilitation services in an inpatient setting include:

- a patient requires 24-hour a day access to a registered nurse (RN) with specialized training in rehabilitation AND

- a patient requires the 24 hour availability of a physician with specialized training or experience in rehabilitation and requires medically necessary physician visits at least every two to three days during the patient's stay due to the presence of a co-morbid medical condition or a risk of change in medical status AND

- a patient's need for specialized equipment at such a frequency and duration as to make it impractical for the patient to use the equipment at an outpatient facility OR

- a patient's need for the level of intensive, interdisciplinary, and highly coordinated rehabilitation services not available as an outpatient, through home health, or in a skilled nursing facility.

Treatments, therapies and equipment used to establish medical necessity must be consistent with the nature and severity of the illness or injury, and consistent with accepted standards of medical practice.

Further information on how to demonstrate that the admission meets the criteria for inpatient rehabilitation can be found in the "Documentation" section

of this LCD.

Coverage stops when further progress toward the established rehabilitation goal is unlikely or when further progress can be achieved in a less intensive setting. In deciding whether further care can be carried out in a less intensive setting, both the degree of improvement that has occurred and the type of program required to achieve further improvement must be considered. In some cases, an individual may be expected to continue to improve under an outpatient program. There are other situations where further improvement in the individual's ability to function relatively independently in the activities of daily living can be expected only if a multidisciplinary team effort is continued.

While occasional home visits and other trips into the community are factors in determining whether continued stay in the hospital is necessary, such excursions alone are not a basis for concluding that further hospital care is not required. Planned home visits and trips to the community are frequently used to test the individual's ability to function outside the institutional setting and assist in discharge planning for the individual.

It is also important to consider how close the patient may be to the planned end of the rehabilitation hospital stay when further progress becomes unlikely. If a patient is within a few days of discharge, transfer to a less intensive setting in another facility would be inappropriate even though further progress in the hospital setting is unlikely. However, it could be appropriate to utilize a "swing bed" arrangement, if it exists in the same facility, for rendering necessary services to the patient pending discharge. CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110.5

A claim that does not fulfill the coverage requirements described above may be given individual consideration based on review of all pertinent medical information. Please see "Documentation Requirements" for some examples of medical information that would be pertinent to such review.

3. **Limitations**

The following paragraphs describe services that would likely be found not reasonable and necessary and therefore would be denied as inpatient rehabilitation services:

- There is no reasonable expectation of improvement in quality of life or level of functioning. (For discussion of the concept of "health-related quality of life" (HRQOL) see, for example, *Measuring Healthy Days: Population Assessment of Health-Related Quality of Life*, published by the Centers for Disease Control and Prevention in November, 2000 and

available at www.cdc.gov/nccdphp/hrqol/pdfs/mhd.pdf.)

- Failure to meet the coverage requirements for inpatient rehabilitation as stated above – i.e. the services are available in a less intensive setting (Outpatient or SNF) and the patient is medically appropriate for such a setting. Determining whether "the services are available" in a less intensive setting includes assessing whether the patient needs a coordinated and inter-disciplinary program of rehabilitation and, if so, whether such a program is available in the less intensive setting.

- The reason for admission is due to a medical condition that is more appropriately considered part of the acute inpatient stay (premature discharge from the acute care hospital to the rehabilitation facility). Examples include a patient who could have been discharged with home or outpatient therapy had he stayed another few days in the acute care setting to treat co-morbid medical conditions or a person transferred to an IRF with a medical problem that prohibits meaningful participation in a rehabilitation program at the time of transfer (e.g. someone on bed rest). A 2003 report to Congress by the Medicare Payment Advisory Commission (MEDPAC) notes that available evidence strongly suggests that increases in post-acute care services reflect the substitution of post-acute care for some inpatient services.

- The physician did not order an intensive level of care as described in this policy and there was no documentation to support an exception to the intensity requirement.

- The facility did not provide the services ordered, such that an intensive multi-disciplinary level of care was not provided for the bulk of the inpatient stay and there was no documentation to support an exception to the intensity requirement.

- Documentation does not support the intensity of service. Three hours of skilled rehabilitative services per day at least five days per week were not provided and there was no documentation to explain why the patient was nevertheless appropriate for inpatient rehabilitation.

- Some or all of the services that contributed to the 3 hour guideline were not skilled or supported as medically necessary.

- Coordinated multi-disciplinary care was not required or provided.

- Services provided after a given date were not medically necessary in an inpatient environment as the patient no longer required an inpatient

level of care. (Documentation does not justify length of stay.)

- The medical record fails to substantiate the data reported in the Inpatient Rehabilitation Facility – Patient Assessment Instrument (IRF-PAI).

- *Since discharge planning is an integral part of any rehabilitation program and should begin upon the patient's admittance to the facility, an extended period of time for discharge action would not be reasonable after established goals have been reached, or a determination made that further progress is unlikely, or that care in a less intensive setting would be appropriate*. CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 1, Section 110.5

- *The absence of preadmission screening in a particular case is not adequate reason for denying a claim. However, in a case where an inpatient assessment showed that a patient clearly was not a good candidate for an inpatient hospital program, then the presence or absence of preadmission screening information is important in determining whether the inpatient assessment itself was reasonable and necessary.* CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110.2

4. **Other Comments**

This Local Coverage Determination consolidates and replaces all previous policies and publications on this subject by the carrier and fiscal intermediary predecessors of National Government Services (AdminaStar Federal, Anthem Health Plans of New Hampshire, Associated Hospital Service, Empire Medicare Services, and United Government Services).

For claims submitted to the fiscal intermediary: This coverage determination also applies within states outside the primary geographic jurisdiction with facilities that have nominated National Government Services to process their claims.

Bill type codes only apply to providers who bill these services to the fiscal intermediary. Bill type codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier.

Limitation of liability and refund requirements apply when denials are based on medical necessity. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be considered medically necessary by Medicare.

The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes. In these instances it is recommended, although not required, that the provider notify the beneficiary in writing with a Notice of Exclusion of Medicare Benefits (NEMB).

Notice to beneficiaries related to discharge and coverage notification as described in CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 2, Sections 80-80.2, applies.

Hospitals have been instructed to provide Hospital-Issued Notices of Noncoverage (HINNs) to beneficiaries prior to admission, at admission, or at any point during an inpatient stay if the hospital determines that the care the beneficiary is receiving, or is about to receive, is not covered because it is:

- Not medically necessary;
- Not delivered in the most appropriate setting; or
- Is custodial in nature.

If the facility portion of inpatient rehabilitation services is denied as not medically necessary this does not mean that the physician service is also not medically necessary. The physician service to the patient may be medically necessary even though the level of service rendered in an inpatient rehabilitation facility is not medically necessary.

Physician visits to a patient must involve a face-to-face encounter. Physician visits that only comprise team conferences or discussion with staff can not be billed to the carrier.

Notes Related to Revision Effective Dates:

12/01/2007-Cor#1

Corrected version of policy published 12/01/2007 (during the Notice Period) with no change in the original effective date of 12/01/2007.

Coverage Topic
Hospital Care (Inpatient)

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

11x Hospital-inpatient (including Part A)

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

0024 - *The Revenue code, Form Locator (FL) 42, Record Type (RT) 60, field 5), (SV201), must contain revenue code 0024. This code indicates that this claim is being paid under the* PPS. This revenue code can *appear on a claim only once*. CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 140.3

When coding PPS *bills for ancillary services associated with a Part A inpatient stay, the traditional revenue codes will continue to be shown in FL 42, e.g., 0250 - Pharmacy, 042x - Physical Therapy, in conjunction with the appropriate entries in Service Units, FL46 and Total Charges, FL47.* CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 3, Section 140.3

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types.

Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

CPT/HCPCS Codes

Not applicable

ICD-9 Codes that Support Medical Necessity

Not applicable

Diagnoses that Support Medical Necessity

Not applicable

ICD-9 Codes that DO NOT Support Medical Necessity

Not applicable

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Not applicable

Diagnoses that DO NOT Support Medical Necessity

Not applicable

General Information

Documentation Requirements

General documentation requirements

Documentation in the clinical record must be descriptive, clearly related to functionality, and indicative of a multi-disciplinary approach. It should be objective, clear, and concise. All clinical services rendered to the patient must be documented and include the credentials of the individual performing the service.

The patient's medical record must contain documentation that fully supports the medical necessity for inpatient rehabilitation as covered by Medicare (see "Indications and Limitations of Coverage"). This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. No particular format is required, but all elements must be identifiable within the record.

The admitting physician's assessment of the patient's rehabilitation potential should be included in the initial documentation. Such assessment should include the anticipated impact of any comorbid conditions. Documentation should describe those factors that influence the decision to provide rehabilitation services in an inpatient hospital, rather than in a less intensive setting, such as SNF, home health, or outpatient. The patient's prior level of functioning, as well as his or her past medical history, and any previous treatment for the admission diagnosis should be documented. The patient's medical record must include the date of onset and/or exacerbation and description of the illness or injury responsible for admission to the IRF.

Current functional status and measurable goals individualized to the needs and abilities of the patient should be a part of the plan of care and progress toward these goals should be evident in the clinical record. Frequent conflicting documentation between disciplines, widely fluctuating patient abilities, or failure to progress as planned should be explained and a realistic plan to address the problem(s) identified. Documentation of discharge plans should be indicated early in the plan of care.

Specific documentation elements to support the medical necessity of IRF admission

1. **The patient requires close medical monitoring and physician oversight while participating in rehabilitation.**

   A patient's condition must require the 24-hour availability of a physician with special training or experience in the field of rehabilitation. This need should be verifiable by entries in the patient's medical record that reflect frequent and direct, and medically necessary physician involvement in the patient's care; i.e., at least every two to three days during the patient's stay. This degree of physician involvement which is greater than is normally rendered to a patient in a SNF is an indicator of a patient's need for services generally available only in a hospital setting. CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110.4.1

   At the time that each Medicare Part A fee-for-service patient is admitted, the inpatient rehabilitation facility must have physician orders for the patient's care during the time the patient is hospitalized. CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110.2.1

   In order to support the medical necessity for the services, the plan of care must contain the following elements:

   - Diagnosis being treated and the specific functional problem areas identified;
   - Comorbidities being managed that require the medical involvement of the physician and how the comorbidities impact the patient's involvement in the plan of care and potential to meet goals.
   - Specific functional and medical goals in measurable terms;
   - Specific professional disciplines, treatment modalities or procedures targeting each specific problem to attain the stated goals;
   - Amount, frequency, and estimated duration of each therapeutic intervention;
   - Documentation at initiation of treatment that there is a reasonable expectation the patient possesses the rehabilitation potential to meet the treatment goals.

Physician progress notes should reflect the need for active and ongoing medical management.

Admission to an IRF from a less intensive therapy setting (e.g. a SNF) will require documentation to justify why intensive inpatient rehabilitation is now appropriate. For example, a patient may be appropriate for transfer to an IRF from a SNF after demonstrating an increased ability to tolerate and actively participate in intensive rehabilitation services. The transferring SNF resident must meet all IRF requirements as noted in the "Indications and Limitations" section.

2. **The patient requires rehabilitation nursing care on a twenty-four hour basis.**

   The patient requires the 24-hour availability of a registered nurse with specialized training or experience in rehabilitation. CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110.4.2

   Documentation should reflect the need for specialized rehabilitation nursing. Examples of nursing documentation reflecting such care might include (but are not limited to) one or more of the following:

   - Progress in bowel and bladder continence or regulation following an injury that impacts such functions.
   - Skin integrity, including positioning techniques and weight shifting to prevent pressure areas in relatively immobile patients, checking for developing problems in body areas with diminished or absent sensation, and care for any wounds or areas of already compromised skin integrity.
   - Ongoing assessment of nutritional and hydration status in patients who are no longer able to eat and/or drink in an adequate manner.
   - Ongoing assessment of safety, including not only physical limitations, but also such cognitive functions as memory, judgment, pathfinding skills, and problem-solving abilities.
   - Ongoing assessment of the effects of treatment implemented by other members of the interdisciplinary team including the patient and/or caregiver's ability to carry over techniques and compensatory mechanisms learned in therapy, and the patient's functional capability throughout a 24 hour period based upon changes in medical stability, pain, endurance or cognition.

- Educational interventions with the patient and/or family members (or other prospective caregivers) in how to maintain optimal health despite changes in the way the patient's body functions. Such interventions may include the provision of information about the patient's injury or condition, training in medical techniques (e.g. tracheostomy care, tube feedings, catheterization, etc.), medication administration and potential side effects, bowel and bladder programs, prevention of complications, what to do in the event that complications arise after discharge, and planning for follow-up medical care.

- Discharge planning – assisting in identification of the patient's special medical needs for after-care including placement following discharge from the IRF, what type of assistance may be needed, who can provide the assistance, what changes need to be made in the patient's discharge environment, and what patient and/or caregiver education is needed to ensure a safe discharge.

3. **The patient requires a relatively intense level of rehabilitation services.**

   The general threshold for establishing the need for inpatient hospital rehabilitation services is that the patient must require and receive at least three hours a day of physical and/or occupational therapy. (The furnishing of services no less than five days a week satisfies the requirement for "daily" services.) While most patients requiring an inpatient stay for rehabilitation need and receive at least three hours a day of physical and/or occupational therapy, there can be exceptions because individual patient's needs vary. In some instances, patients who require inpatient hospital rehabilitation services may need, on a priority basis, other skilled rehabilitative modalities such as speech-language pathology services, or prosthetic-orthotic services and their stage of recovery makes the concurrent receipt of intensive physical therapy or occupational therapy services inappropriate. In such cases, the 3-hour a day requirement can be met by a combination of these other therapeutic services instead of or in addition to physical therapy and/ or occupational therapy. CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110.4.3

   The "three hour rule" (patient receiving at least 3 hours of skilled therapy at least 5 days per week) should not be considered an inflexible rule of thumb; however, a patient receiving a less intensive schedule of therapy will require additional documentation to explain why he or she requires an inpatient rehabilitation facility level of care. There may be patients who are not able to tolerate 3 hours of daily therapy upon admission to the IRF but are able to

build up to that level of intensity within a reasonable time period. There may be patients who cannot participate in three hours of therapy but whose medical complexity or fragility require the intensive medical and nursing services available at an IRF in order to safely participate in rehabilitation. Documentation should justify the medical necessity and appropriateness for IRF admission despite the lower level of therapy intensity.

In order to support the medical necessity for substituting other therapy or services in lieu of physical and/or occupational therapy (e.g., speech-language pathology or prosthetic-orthotic services), the documentation must clearly state why this is required for the particular patient and how it fits into the multidisciplinary team approach and coordinated program of care. Additional diagnostic or therapeutic services that are rendered to the beneficiary but are not medically necessary for the patient's condition that requires IRF admission should not be counted toward the three hour rule. For example, upper extremity range of motion exercises for a patient admitted for an acute fractured hip.

CMS notes that *an inpatient stay for rehabilitation care can also be covered even though the patient has a secondary diagnosis or medical complication that prevents participation in a program consisting of three hours of therapy a day. Inpatient hospital care in these cases may be the only reasonable means by which even a low intensity rehabilitation program may be carried out.* [During medical review] (t) *he intermediary secures documentation of the existence and extent of complicating conditions affecting the carrying out of a rehabilitation program to ensure that inpatient hospital care for less than intensive rehabilitation care is actually needed*. CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110.4.3

4. **The patient requires a coordinated, multi-disciplinary team approach to rehabilitation.**

One of the distinguishing features of an IRF is that care is typically provided by many different disciplines working together in a coordinated fashion. Documentation should reflect not only the active involvement of multiple clinical disciplines (multi-disciplinary), but also the inter-disciplinary nature of their treatment.

A multidisciplinary team usually includes a physician, rehabilitation nurse, social worker and/or psychologist, and those therapists involved in the patient's care. At a minimum, a team must include a physician, rehabilitation nurse, and one therapist. CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110.4.4

*The patient's records must reflect evidence of a coordinated program, i.e., documentation that periodic team conferences were held with a regularity of at least every **two weeks** to:*

- *Assess the individual's progress or the problems impeding progress;*
- *Consider possible resolutions to such problems; and*
- *Reassess the validity of the rehabilitation goals initially established.*

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. 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 clinical record. CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110.4.5

Although CMS requires the frequency of team conference to be "at least every two weeks", more frequent (e.g. weekly) team conferences may be more consistent with the current standard of practice and be required to effectively demonstrate that the requisite inter-disciplinary intensive rehabilitation is being provided and the patient is making measurable progress.

Progress should be documented in measurable terms. For example, documentation that a patient is "able to ambulate better with less assistance but continues to need physical therapy" is too imprecise. An example of documentation in measurable terms is "Patient is able to ambulate 20 feet with use of a quad cane and minimal assistance, an improvement over his ability to ambulate 10 feet with a rolling walker and moderate assistance one week ago. Short term goal is for patient to ambulate 50 feet with a quad cane and contact guard; long-term goal is for patient to ambulate independently with a straight cane at least 200 feet." It isn't necessary to include all the elements in one note as in the example above, but the past functional status, present functional status, and remaining goals should be readily identifiable in the clinical documentation. (For definitions of "moderate" and "minimal" assistance as well as other measurement terms used in the Functional Independence Measure (FIM ™), see the *IRF-PAI Training Manual*, effective 4/1/04.)

Functional progress is not required in every element of the FIM ™ every

week, but the overall trend should be towards increased functionality. A sustained period of non-progress in any area requires documentation on plans to address the lack of progress through either a change in treatment or by downgrading goals in that area.

1. **The patient demonstrates the potential for significant practical improvement.**

   Hospitalization after the pre-admission screening [and/or the initial inpatient assessment] *is covered only in those cases where the pre-admission screening* [and/or the initial inpatient assessment] *results in a conclusion by the rehabilitation team that a significant practical improvement can be expected in a reasonable period of time. It is not necessary that there be an expectation of complete independence in the activities of daily living, but there must be a reasonable expectation of improvement that is of practical value to the patient, measured against the patient's condition at the start of the rehabilitation program. For example, a multiple sclerosis patient's condition may have deteriorated as a result of a secondary illness. To be restored to a level of function before the secondary illness, the patient may require an intensive inpatient hospital rehabilitation program. While such a program does not restore the level of function before multiple sclerosis developed, a return to pre-secondary illness level is considered to be a "significant practical improvement" in the condition. In addition, a beneficiary must classify into one of the CMG's* [sic] *payable by Medicare under the IRF PPS*. CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110.4.6

   "Significant practical improvement" is evaluated in the context of the individual patient's physical impairment and any co-morbid factors. For example, a patient being admitted for rehabilitation after a stroke who also has diabetes, coronary artery disease, hypertension, and a lower extremity amputation may not tolerate the same intensity of rehabilitation or progress as quickly or as far as an otherwise healthy stroke survivor, but this doesn't preclude significant practical improvement. The healthier patient may have goals to ambulate with an assistive device and ultimately return to independent living, while the less healthy patient has the more modest goals of returning home with assistance and using a wheelchair independently. That is still a significant practical improvement compared with admission to a nursing home or being confined to bed. Significant practical improvement in a patient with paraplegia might include learning to manage a wheelchair, transfer back and forth from the wheelchair to bed, toilet, car, etc., and dress, bathe, and toilet himself independently. Significant practical improvement for a patient with quadriplegia may include learning how to

direct others in his day to day care needs, achieve independent mobility with a customized electric wheelchair, and use adaptive devices such as a mouth-stick or remote control unit for increased independence in controlling his environment.

2. **The patient has realistic goals requiring inpatient rehabilitation.**

Both short term and long term goals should be documented.

Goals should be measurable and stated in terms of their functional impact. A goal of ambulating only 2-3 feet without assistance may appear to be of little functional use to a patient unless it is also noted that he or she lives in a home with no accessible bathroom facilities, thus necessitating his or her ability to leave the wheelchair in the bathroom doorway and ambulate a few steps to the toilet or shower chair.

Goals should reflect the inter-disciplinary nature of intensive inpatient rehabilitation – for example, a long term goal of independent bathing may require physical therapy to work on transfer techniques, occupational therapy to work on adaptive mechanisms for washing all body parts, and nursing to assess how well the patient remembers and follows through with these skills outside of therapy. Goals may also include education and training activities with care givers who will be responsible for assisting the patient upon discharge.

Realistic goals consider the individual patient's circumstances and functional level. For example, realistic discharge destination goals may differ between two patients with the capacity to achieve the same functional status after intensive rehabilitation, depending on the availability of practical assistance and/or financial resources to which they have access upon discharge.

While there may be instances where an intense rehabilitation program may enable a Medicare patient to return to the labor market, vocational rehabilitation is generally not considered a realistic goal for most aged or severely disabled individuals. The most realistic rehabilitation goal for most Medicare beneficiaries is self-care or independence in the activities of daily living; i.e., self-sufficiency in bathing, ambulation, eating, dressing, homemaking, etc., or sufficient improvement to allow a patient to live at home with family assistance rather than in an institution. Thus, the aim of the treatment is achieving the maximum level of function possible. CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 1, Section 110.4.7

If the patient has not made the projected amount of progress between team

conferences, documentation should include the reason (if known) and the plan for changes in the goals and/or treatment program if necessary.

In addition to the specific requirements listed elsewhere in this LCD, physician progress notes should:

- Reflect the need for management and coordination of the multidisciplinary rehabilitation team,
- Describe the effectiveness of the previously ordered rehabilitation therapy,
- Identify issues which need changes to therapy,
- Identify problem/obstacles encountered in the therapeutic process, and
- State the plan for resolution of the identified problems/obstacles to the plan of care.

Appendices
Not applicable
Utilization Guidelines
Not applicable
Sources of Information and Basis for Decision
This bibliography presents those sources that were obtained during the development of this policy. National Government Services contractor is not responsible for the continuing viability of Web site addresses listed below.

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Advisory Committee Meeting Notes
Carrier Advisory Committee Meeting Date(s)

06/13/2007 New Jersey and New York
06/25/2007 Indiana
06/28/2007 Kentucky

This coverage determination does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the contractor, this determination was developed in consultation with representatives from Advisory Committee members and/or from various state and local provider organizations.

Start Date of Comment Period
06/01/2007
End Date of Comment Period
07/16/2007
Start Date of Notice Period
10/01/2007
Revision History Number
Cor#1 - Corrected version published 11/07/2007 during the Notice Period
Revision History Explanation

Cor#1 - Corrected version (published 11/07/2007 during the Notice Period) (effective 12/01/2007): The following paragraph has been removed from the above named LCD currently in notice that becomes effective December 1, 2007: "Patients who require an inpatient level of rehabilitation generally need relatively intense therapy. Intense therapy would be expected to be provided in 1:1 patient-therapist contact for a majority of patients in the IRF. Although individual therapist patient contact is required for the majority of patients in an IRF, there may be some patients that benefit from therapy provided in a group setting. The documentation should clearly state the reason for providing the group therapy. Group therapy is not a service that contributes to meeting the 'three hour rule'."

Reason for Change

Narrative Change

Last Reviewed On Date

11/07/2007

Related Documents

Article(s)

A44851 - Inpatient Rehabilitation Services Provided in an Inpatient Rehabilitation Facility (IRF) - Supplemental Instructions Article

LCD Attachments

Comment & Response Article for Inpatient Rehabilitation Services Provided in an Inpatient Rehabilitation Facility (IRF) - Comment and Response (48,876 bytes)

APPENDIX C

Inclusive Language Removed from LCD L25714

The patient requires the active and ongoing therapeutic intervention of at least two disciplines (physical therapy, rehabilitation nursing, occupational therapy, speech therapy, psychology, social work, prosthetics/orthotics, therapeutic recreation), one of which must be physical or occupational therapy, acting in a coordinated fashion and based on the patient's needs, AND

APPENDIX D

Congress of the United States
House of Representatives
Washington, D.C. 20515

May 4, 2009

Charlene M. Frizzera
Acting Administrator
Centers for Medicare and Medicaid Services
Hubert H. Humphrey Building, Suite 314G
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Ms. Frizzera:

We request that the Centers for Medicare and Medicaid Services (CMS) include recreational therapy in the listing of other skilled modalities within Section 110.4.3 of the Medicare Benefits Policy Manual (MBPM).

Recreational therapy is a health care discipline that delivers treatment services designed to restore, remediate and/or rehabilitate functional capabilities for persons with injuries, chronic illnesses, and all disabilities. Recreational therapists utilize a wide range of therapeutic modalities, community-based interventions, and rehabilitative techniques to assist patients in developing functional skills for daily living and community involvement. These therapy services are prescribed and supervised by a physician as part of the patient's treatment plan. Such services constitute active treatment to improve the physical, cognitive, social and emotional functioning of individuals undergoing rehabilitation. For years, Medicare has considered recreational therapy as a covered service in inpatient rehabilitation hospitals and units (IRFs), inpatient psychiatric hospitals and units (IPFs), and skilled nursing facilities (SNFs) and has incorporated the costs of providing this therapy into the prospective payment systems in each setting.

We understand, however, that the language of the regulations and manual provisions issued by CMS leaves considerable ambiguity on the inclusion of recreational therapy services as covered benefits in IRFs, IPFs, and SNFs. If the Medicare program is paying for these services through prospective payment rates, patients who need recreational therapy ought to be able to access these benefits.

In the inpatient rehabilitation hospital/unit context, CMS could resolve this ambiguity simply by clarifying that recreational therapy meets the definition of the 3-hour per day therapy guideline that appears in Section 110.4.3 of the MBPM, Relatively Intensive Level of Rehabilitation Services. This would clarify that rehabilitation physicians may use recreational therapy, in consultation with the rehabilitation team, in the mix of services provided to rehabilitation inpatients to achieve a relatively intense level of rehabilitation care, assuming these services are medically necessary and prescribed by the physician as part of a patient's treatment plan.

The language of the 3-hour guideline in the MBPM already appears to permit services other than the ones listed below to be counted, on a priority basis, under the 3-hour guideline. We request that CMS remove all ambiguity and publish a revision to the 3-hour guideline that specifically

includes recreational therapy in the listing of other skilled modalities. The requested modification (in bold) of MBPM Sec. 110.4.3 would read:

> "While most patients requiring an inpatient stay for rehabilitation need and receive at least three hours a day of physical and/or occupational therapy, there can be exceptions because an individual patient's needs vary. In some instances, patients who require inpatient hospital rehabilitation services may need, on a priority basis, other skilled rehabilitative modalities such as speech-language pathology services, ~~or~~ prosthetic-orthotic services, or **recreational therapy services** and their state of recovery makes the concurrent receipt of intensive physical therapy or occupational therapy services inappropriate."

We understand that the lack of clarity of recreational therapy coverage in the IPF or SNF settings causes similar confusion in the field which leads to inconsistent access to these benefits in IPFs and SNFs. We ask that CMS clarify through the MBPM or through issuance of regulations that recreational therapy is a covered service and that the costs of providing these services are incorporated into the prospective payment systems of IPFs and SNFs.

We believe that amending the Medicare Benefits Policy Manual to clarify coverage of recreational therapy in these three inpatient settings within the 3-hour guideline will ensure that Medicare beneficiaries have consistent access to these services across the country. Thank you for your consideration of our concerns on this matter and we look forward to your response.

Sincerely,

Ellen O. Tauscher
Member of Congress

Glenn Thompson
Member of Congress

Tammy Baldwin
Member of Congress

G.K. Butterfield
Member of Congress

Howard Coble
Member of Congress

Charles W. Dent
Member of Congress

Vernon J. Ehlers
Member of Congress

Brad Ellsworth
Member of Congress

Sam Farr
Member of Congress

Jim Gerlach
Member of Congress

Alcee L. Hastings
Member of Congress

Walter B. Jones
Member of Congress

Peter T. King
Member of Congress

Cynthia M. Lummis
Member of Congress

Patrick T. McHenry
Member of Congress

Todd Russell Platts
Member of Congress

Nick J. Rahall
Member of Congress

Denny Rehberg
Member of Congress

Janice D. Schakowsky
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Michael K. Simpson
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Zach Wamp
Member of Congress