LCD for Inpatient Rehabilitation Services (L19890)

Contractor Information

Contractor Name

Mutual of Omaha Insurance Company

Contractor Number

52280

Contractor Type

FI

LCD Information

LCD ID Number

L19890

LCD Title

Inpatient Rehabilitation Services

Contractor's Determination Number

2005-02

AMA CPT / ADA CDT Copyright Statement

CMS National Coverage Policy

Social Security Act:

§ 1833 (a)(8)(B)(I) allows payment for ancillary services and therapies when Part coverage is not made.

§ 1833 (e) prohibits Medicare Payment for any claim which lacks the necessary information to process the claim.

§ 1861(v)(1)(G) 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.

§1862 (a)(1)(A) This section allows coverage and payment for only those services that are considered to be reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member.

§1862 (a)(7) excludes routine physical examination.

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§ 1886 (d)(1)(b)(iv) and (j) describes the current IRF-PPS information.

Code of Federal Regulations (42 CFR):

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

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

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

§ 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:

100-2, Medicare Benefit Policy Manual, Chapter 1, §§ 110.1 through 110.5 defines coverage guidelines for Inpatient Rehabilitation Facility stays.

100-4, Medicare Claims Processing Manual, Chapter 3, §130.1 through 130.9 provides instructions related to non-coverage notification and financial liability.

100-4, Medicare Claims Processing Manual, Chapter 3, §140.1 Criteria that must be met by Inpatient Rehabilitation hospitals.

100-4, Medicare Claims Processing Manual, Chapter 3, § 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.

CMS Change Request 3503, October 29, 2004.

CMS Change Request 3334, June 25, 2004.

CMS Joint Signature Memorandum, January 25, 2005

Primary Geographic Jurisdiction

Alaska
Alabama
Arizona
California - Entire State
Colorado

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Connecticut
Delaware
Florida
Georgia
Hawaii
Iowa
Idaho
Illinois
Indiana
Kansas
Kentucky
Louisiana
Massachusetts
Maryland
Maine
Michigan
Minnesota
Missouri - Entire State
Mississippi
Montana
North Carolina
North Dakota
Nebraska
New Hampshire
New Jersey
New Mexico
Nevada
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Virginia
Vermont
Washington
Wisconsin
West Virginia
Wyoming

Secondary Geographic Jurisdiction

Oversight Region

Region VII

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Original Determination Effective Date

For services performed on or after 05/14/2005

Original Determination Ending Date

Revision Effective Date

For services performed on or after 09/28/2006

Revision Ending Date

Indications and Limitations of Coverage and/or Medical Necessity

ABSTRACT:

This local coverage determination (LCD) addresses Medicare coverage for inpatient rehabilitation services provided in freestanding and "excluded" [as defined in 42 CFR, Section 412.25] rehabilitation units . For the purposes of this LCD, a distinction exists between the so-called percent rule and medical necessity. The percent rule is an accounting standard by which facilities are classified as IRFs by CMS; whereas, medical necessity is a medical review standard by which IRF admissions are deemed reasonable and necessary. A facility's classification by CMS as an IRF does not imply that a given patient's stay in that IRF meets medical necessity requirements. The medical necessity for the provision of *inpatient hospital rehabilitation services* is the primary focus of this LCD.

A distinction exists between the medical necessity for provision of individual therapy services and the medical necessity for the setting where those services are provided. Individual therapy services may be reasonable and necessary in a particular case, while the provision of those services in a *rehabilitation hospital* may not be medically necessary. This LCD describes the relevant factors that differentiate Medicare coverage for *rehabilitative care in a hospital* from coverage for rehabilitative care in other settings such as acute care medical or surgical hospitals, skilled nursing facilities (SNFs), home health care, and outpatient settings.

Portions of the Medicare Benefit Policy Manual (CMS PUB 100-02) cited in this LCD are marked in italics. This LCD is not intended to replace or re-quote the entire language in the Medicare Benefit Policy Manual but to highlight portions of this Section that warrant further interpretation, guidance, and education for coverage. The fact that all language from CMS PUB 100-02 is not included in this LCD does not diminish its composite authority.

Throughout this LCD, IRF stays will be referred to by these interchangeable CMS terms: *IRF, inpatient hospital stay for rehabilitation care, rehabilitative care in a hospital, inpatient hospital rehabilitation services, inpatient stay for rehabilitation care, or rehabilitation hospital.*

(a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

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(1)(A) which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member SEC. 1862. [42 U.S.C. 1395y]

Regulatory Basis for Inpatient Rehabilitation

There is a regulatory limitation on coverage for inpatient rehabilitation that is based on the Social Security Act and published Medicare regulations. These regulations are not part of an LCD. Rather, they set limits on coverage an LCD may not exceed. The most significant regulations that constrain medical necessity determinations follow:

A hospital level of care is required by a patient needing rehabilitative services if that patient needs a relatively intense rehabilitation program that requires a multidisciplinary coordinated team approach to upgrade his ability to function. There are two basic requirements that must be met for inpatient hospital stays for rehabilitation care to be covered:

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

It must be reasonable and necessary to furnish the care on an inpatient hospital basis, rather than in a less intensive setting such as an SNF (Skilled Nursing Facility), a SNF level of care in a swing bed hospital, or on an outpatient basis. (CMS Pub 100-02, Chapter 1, § 110.1)

Rehabilitative care in a hospital (rather than in an SNF or swing bed or on an outpatient basis) is reasonable and necessary for a patient who requires a more coordinated, intensive program of multiple services than is ordinarily available out of a hospital. A patient who has one or more conditions requiring intensive and multidisciplinary rehabilitation care, or who has a medical complication in addition to his primary condition, so that the continuing availability of a physician is required to ensure safe and effective treatment, probably requires a hospital level of rehabilitation care. (CMS Pub 100-02, Chapter 1, § 110.1).

Absent other complicating medical problems, the type of rehabilitation program normally required by a patient with a fractured hip during or after the non-weight bearing period or a patient with a healed ankle fracture would not require an inpatient hospital stay for rehabilitation care. (CMS Pub 100-02, Chapter 1, § 110.3.2)

Due to the unique considerations of each individual inpatient admission, automated review of inpatient hospital stays for rehabilitation care is not performed. *Medicare recognizes that determinations of whether hospital stays for rehabilitation services are reasonable and necessary must be based upon an assessment of each beneficiary's individual care needs. Therefore, denials of services based on numerical utilization screens, diagnostic screens, diagnosis or specific treatment norms, "the three hour rule," or any other "rules of thumb," are not appropriate.* (CMS Pub 100-02, Chapter 1, § 110.1)

Indications

Physicians generally agree on the circumstances that justify a medical or surgical patient's hospitalization. In addition, in some cases an admission to a rehabilitation hospital or to the rehabilitation service of a short-term hospital can be justified on essentially the same medical or surgical grounds. In other cases, however, a patient's medical or surgical needs alone may not warrant inpatient hospital care, but hospitalization may nevertheless be necessary because of the patient's need for rehabilitative services. (CMS Pub 100-02, Chapter 1, § 110.1)

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In any case, the criteria for the stay that are peculiar to rehabilitation must be met for the stay to be deemed medically necessary (see next section). *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:*

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

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 Pub 100-02, Chapter 1, § 110.1)

Criteria for Coverage of Inpatient Rehabilitative Services

A. IRF Criteria Documentation: The following criteria shall be documented in support of coverage for an IRF hospitalization. This list is inclusive.

1. ***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 Pub 100-02, Chapter 1, § 110.4.3).

In order to allow other therapy or services in lieu of physical and/or occupational therapy, the documentation must state clearly the reason this is necessary for this patient at the IRF level of care. The documentation must record the actual daily minutes of therapeutic services provided. Also, documentation must show the incorporation of therapy or therapeutic services into the multi-disciplinary team approach and coordinated program of care (see below: # 5 and 6).

b. Physical therapy, occupational therapy, or speech therapy, or audiology services, if provided, must be provided by staff who meet the qualifications specified by the medical staff, consistent with State law. (42 CR 482.56)

In accordance with 482.56, IRF therapy furnished according to State law is provided in accordance with Medicare requirements.
Accurate reporting of actual daily minutes of therapy provided by each discipline shall be documented in the medical record.

c. 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. The 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 Pub 100-02, Chapter 1, § 110.4.3).

In these cases, the IRF documentation must establish that this less than intensive level of rehabilitative care must be provided in the IRF because of the complicating surgical and/or medical condition(s). Accordingly, the patient's need for a coordinated multidisciplinary rehabilitation program must be documented according to the rest of the requirements in this section. Specific reasons and individual considerations related to the particular patient which are documented initially and reconsidered throughout the coordinated plan of care records would support such an assertion.

2. ***Significant Practical Improvement and Realistic Goals***

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. 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. . . . . In addition, a beneficiary must classify into one of the CMG's payable by Medicare under the IRF PPS. (CMS Pub 100-02, Chapter 1, § 110.4.6)

Please see section B that follows for further discussion of pre-admission screening. Complete independence in the activities of daily living before the patient is discharged from the IRF is not a necessary expectation. Neither is vocational rehabilitation considered a realistic goal. *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 Pub 100-02, Chapter 1, § 110.4.7)

3. ***Close Medical Supervision by a Physician With Specialized Training or Experience 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 Pub 100-02, Chapter 1, § 110.4.1)

The documentation must demonstrate that this physician with special training or experience in the field of rehabilitation provided frequent, direct, and medically-necessary medical care and supervision that facilitated and accommodated the achievement of the patient's individual rehabilitation goals during the admission.

4. ***Twenty-Four Hour Rehabilitation Nursing***
The patient requires the 24-hour availability of a registered nurse with specialized training or experience in rehabilitation. (CMS Pub 100-02, Chapter 1, § 110.4.2)
The documentation must support the availability of this nurse and demonstrate the provision of nursing care that addresses the primary and on-going provision of rehabilitation nursing in the context of the multi-disciplinary team and the coordinated program of care in meeting the patient's particular and dynamic rehabilitative needs.

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5. ***Multi-Disciplinary Team Approach to Delivery of Program and Coordinated Program of Care***
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 Pub 100-02, Chapter 1, § 110.4.4). 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.

The patient's record 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.

c. 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 Pub 100-02, Chapter 1, § 110.4.5).The patient's plan of care is developed and managed by a coordinated multi-disciplinary team. Although CMS requires the frequency of team conference to be "at least every two weeks", more frequent team conferences may be indicated, as in the case of a stay lasting less than two weeks, to effectively demonstrate that the required inter- disciplinary intensive rehabilitation if being provided and the patient is making measurable progress.

B. Pre Admision Screening: Evaluation for appropriateness for IRF admission is most commonly accomplished by a pre admission screening. A pre admission screening is not a required document for every covered IRF admission. However, when an *inpatient stay for rehabilitation care* is initiated for the purpose of performing an inpatient rehabilitation assessment, the pre-admission screening is an essential documentation.

Before a patient is admitted to a rehabilitation hospital for treatment, a pre- admission 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 pre-admission screening is a standard practice in most rehabilitation hospitals and may provide useful information for claims review purposes, the absence of pre-admission 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 pre-admission screening information is important in determining whether the inpatient assessment itself was reasonable and necessary.*** *[emphasis added] If pre-admission 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 pre-admission screening cannot be expected to eliminate all unsuitable candidates.* (CMS Pub 100-02, Chapter 1, § 110.2)

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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 *rehabilitation hospital.* It is important to note, in this case, the assessment process is not merely a paperwork review, but rather an on-site professional review of the patient's condition by the necessary disciplines in the IRF. An inpatient assessment in an IRF may be covered even if the assessment subsequently indicates the patient is not suitable for an intensive inpatient hospital rehabilitation program, provided the patient's condition on admission to the IRF documents the medical necessity for an extensive inpatient IRF assessment of a patient's actual rehabilitation potential. Where this IRF inpatient assessment results in a conclusion that the individual is a poor candidate for *rehabilitative care in a hospital*, coverage for further inpatient hospital care is limited to a reasonable number of days needed to permit appropriate placement of the patient.

C. Inpatient Assessment: Inpatient assessments of status and potential for rehabilitation is completed and reported according to CMS patient assessment instrument (PAI).

1. Initial: *Medicare Part A fee-for service beneficiaries in IRFs are assessed by a clinician using the CMS' patient assessment instrument upon admission and at discharge. The CMS' patient assessment instrument consists of nine sections, each to collect different categories of patient information. These categories include identification and demographic information about the patient, medical information, and information related to quality of care and basic patientsafety. IRFs must computerize and electronically report the patient assessment data.*
In general, the admission assessment must have an assessment reference date of day three of the IRF stay, be based upon observations done in the first three days of the IRF stay and be completed by day 4 of the IRF stay. (CMS Pub 100-02, Chapter 1, § 110.3)

2. Discharge: *The discharge assessment must have an assessment reference date that is the actual day that one of two events occurs first: (1) the day on which the patient is discharged from the IRF; or (2) the day on which the patient dies. The discharge assessment is based upon observations done in the three calendar days prior to and including the assessment reference date on the discharge assessment. The discharge assessment must be completed by the 5th calendar day that follows the discharge assessment reference date with the discharge assessment reference date itself being counted as the first day of the five calendar day time period.* (CMS Pub 100-02, Chapter 1, § 110.3)

3. Interrupted stay: *In certain cases, a beneficiary may have an interrupted stay that may affect the assessment reference dates, completion dates, and encoding date. An interrupted stay is defined as one in which an IRF patient is discharged from the IRF and returns to the same IRF within three consecutive calendar days that begins with the day of discharge and ends on midnight of the third day. When a beneficiary has an interrupted stay, the interrupted stay must be documented on the assessment instrument. If the interruption is less than three calendar days, the IRF does not need to complete a new admission assessment. However, in those cases where the patient is discharged and returns after three consecutive calendar days, the IRF is required to complete a new admission assessment.* (CMS Pub 100-02, Chapter 1, § 110.3)

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D. Effects of Illness or Injury: The need for inpatient rehabilitation is more dependent on the effects of a patient's injury or illness, such as impairments, functional deficits, achievable goals, than on the precipitating cause (primary diagnosis). CMS has posted a list of conditions that are used for classification purposes (CMS Pub 100-04, Chapter 3, § 140.1.1). While that list offers broad guidelines for what would potentially be considered medically necessary for coverage for IRF admissions, attention is better directed to satisfying the medical necessity criteria (see A, above) on a case-by-case basis. It is not a specific diagnosis that determines the medical necessity of an inpatient hospital stay for rehabilitation care, but rather it is the documentation that the above criteria are satisfied. Even so, consider that an inpatient hospital stay for rehabilitation care is typically not covered for these select conditions because meeting all the criteria for medical necessity would be unlikely: single extremity deficits (except amputations), simple fractures, single joint replacement, compression fractures and laminectomies/fusions, diffuse weakness or general debility, post-op recovery, and niche rehabilitation (coma, cognitive, cardiac, pulmonary, pain, etc.).

Limitations

The following 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.

Failure to meet the general indications for inpatient rehabilitation as stated in the "Indications" section.

The reason for admission is due to a medical condition that is more appropriately considered part of the acute inpatient stay.

The physician did not order an intensive level of rehabilitative care and there was not documentation to support an exception to the intensity requirement.

Some or all of the services that contributed to the 3-hour guidelines were not skilled.

Documentation did not support that coordinated multi-disciplinary care was required or provided.

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 not documentation to explain why the patient was appropriate for inpatient rehabilitation.

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

Documentation does not justify length of stay

Coverage Topic

Hospital Care (Inpatient)

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Occupational Therapy
Physical, Occupational, and Speech Therapy

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.

0	TBD

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.

99999	Not Applicable

CPT/HCPCS Codes

XX000	Not Applicable

ICD-9 Codes that Support Medical Necessity

It is the providers responsibility to chose the ICD-9 code or codes that identify the patients disease process(s). It is the responsibility of the provider to code to the highest level specified in the ICD-9-CM (e.g., to the fourth or fifth digit). The correct use of an ICD-9-CM codes does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.

XX000	Not Applicable

Diagnoses that Support Medical Necessity

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.

ICD-9 Codes that DO NOT Support Medical Necessity

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

Diagnoses that DO NOT Support Medical Necessity

General Information

Documentation Requirements

General documentation requirements
Documentation in the clinical record must be descriptive, clearly related to functionality, and indicative of a coordinated multi-disciplinary approach. It should be objective, clear, and concise. All clinical services rendered to the patient must be documented, including 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. (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.

Current functional status and measurable goals individualized to the needs and abilities of the patient must be a part of the plan of care and progress toward these goals must be evident in the clinical record. Conflicting documentation between disciplines, widely fluctuating patient abilities, or failure to progress as planned must 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. The rehabilitative physician's assessment of the patient’s rehabilitation potential must be included in the initial documentation, including the anticipated impact of any co-morbid conditions. The patient’s prior level of function, as well as his or her past medical history, and any previous treatment for the admission diagnosis must 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.

The patient’s plan of care during an IRF hospitalization is a product of the multi-disciplinary team. After an evaluation has been performed by each clinician on the team (e.g. rehab nurse, therapist, etc.), this evaluation information is then used by the team to establish and document the plan of care. Documentation must reflect the ongoing assessments and/or adjustments to the plan of care.

General Information

Documentation Requirements

Documentation in the clinical record must be:

Descriptive, objective and concise
Clearly related to functionality indicative of a multi-disciplinary approach
Legible

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 hospital rehabilitation services*
The following documents should be provided with any Additional Development Request:

Admission History and Physical including pertinent information from prior acute care stay

Physician Discharge Summary as well as DC Summaries for any and all disciplines

Physician Orders

Physician Progress Notes

Initial Therapy Assessment (or Preadmission Assessment)(if performed)

Therapy Reassessments

Team Evaluation Notes

Daily Therapy and Nurses Notes as well as any and all Weekly Narratives

IRF-PAI

Reasonable, measurable and reportable goals must be documented in a written plan of care.

The initial physician evaluation consists of the admission history and physical and or admission note combined with the initial orders. These documents between them should clearly communicate the ASSESSMENT and PLAN of the admitting physician. It is expected that they will contain (either explicitly or implicitly) the reason for admission, the therapy required, the anticipated course and the expected goals.

The remainder of the records serves to document ongoing care, validating the medical necessity for continuing therapy as well as recording the fact that the needed services were provided as ordered.

1. Orders must specify the type and goal of therapy as well as any restrictions or precautions.

2. Progress notes must demonstrate ongoing physician involvement, at least every two to three days.

3. Therapy notes must be written (or electronically created) daily. Notes should be created by the discipline (e.g. PT, OT, etc.) providing the service, should convey clinical information about the specific patient and the specific encounter, and should identify the level (certification) of the provider.

Documentation Requirements

4. Team evaluation notes or physician progress notes should contain any revisions to the expectations of the anticipated course and predicted gains.

5. The initial and follow-up assessments should contain quantifiable information regarding functional progress.

6. The documentation in the PAI must conform to Medicare requirements for IRF-PPS.

Appendices

Utilization Guidelines

Reimbursement is based on the Rehabilitation Impairment Category (RIC) that is reported by the facility. Information used to determine the RIC must be present in the Patient Assessment Instrument (IRF-PAI) and substantiated by the medical record. Failure of the IRF-PAI to support the RIC and failure of the medical record to substantiate the data reported in the IRF-PAI will both be considered to constitute coding errors and may result in total denial of the claim.

Sources of Information and Basis for Decision

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General Information

Documentation Requirements

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General Information

Documentation Requirements

Ward D., Severs M., Dean T., Brooks N. *Care Home Versus Hospital and Own Home Environments for Rehabilitation of Older People* (Cochrane Review). Available at: http://www.update-software.com/abstracts/ab003164.htm (abstract of article from The Cochrane Library, Issue 2, 2003).

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Advisory Committee Meeting Notes

This policy does not reflect the sole opinion of the contractor or contractor medical director (CMD). Although the final decision rests with the contractor, this policy was developed in consideration of input from relevant interested parties, including other fiscal intermediaries, CMD workgroup discussions and communication, and correspondence with medical societies, industry, other intermediaries, and other providers.

Start Date of Comment Period

06/28/2006

End Date of Comment Period

08/11/2006

Start Date of Notice Period

08/15/2006

Revision History Number

1
2
3

Revision History Explanation

09/04/2007. Annual review. No limitations changed. No notice necessary, none given.

General Information

Documentation Requirements

09/07/2006 References and SEC. 1862. [42 U.S.C. 1395y] added.

08/15/2006 LCD posted to final all comments were noted.

06/23/2006 Substantive changes were made in the Indications and Limitations of Coverage and/or Medical Necessity of the Inpatient Rehabilitation Facility.

Reason for Change

Maintenance (annual review with new changes, formatting, etc.)

Last Reviewed On Date

09/04/2007

Related Documents

This LCD has no Related Documents.

LCD Attachments

There are no attachments for this LCD.

Other Versions

Updated on 09/07/2006 with effective dates 09/28/2006 - N/A

Updated on 09/19/2005 with effective dates 05/15/2005 - 09/27/2006

Updated on 09/08/2005 with effective dates 05/15/2005 - N/A

Updated on 06/13/2005 with effective dates 05/14/2005 - N/A