I. SCOPE:

This policy applies to (1) Tenet Healthcare Corporation and its wholly-owned subsidiaries and affiliates (each, an “Affiliate”); (2) any other entity or organization in which an Affiliate owns a direct or indirect equity interest greater than 50%; and (3) any hospital or healthcare facility (each, a “Tenet Facility”) that provides Acute Inpatient Rehabilitation Facility services and an Affiliate either manages or controls the day-to-day operations of the facility (each, a “Tenet Inpatient Rehabilitation Facility” or “Tenet IRF”); (collectively, “Tenet”).

II. PURPOSE:

The purposes of this policy are to ensure that patients are admitted to Tenet’s IRFs based on appropriate admission criteria and that all care provided in the IRF is reasonable and necessary as it applies to decisions for admission, continued stay and determination of the timing for discharge.

III. DEFINITIONS:

A. “Federal health care program” means any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government, including, but not limited to, Medicare, Medicaid/MediCal, managed Medicare/Medicaid/MediCal, TriCare/VA/CHAMPUS, SCHIP, Federal Employees Health Benefit Plan, Indian Health Services, Health Services for Peace Corp Volunteers, Railroad Retirement Benefits, Black Lung Program, Services Provided to Federal Prisoners, Preexisting Condition Insurance Plans (PCIPs) and Section 1011 Requests.

B. “Inpatient Rehabilitation Facility Program Director” or “IRF Program Director” means the individual employed by the Tenet Facility to manage the IRF unit.

C. “Managed Care Payer” means, for the purposes of this policy, any contracted third party payor who pays, or is expected to pay, benefits to the Facility under a health insurance policy. Although not typically included as a Managed Care Payer in Tenet policies, for purposes of this policy, Managed Care Payer includes managed Federal health care programs (e.g., managed Medicare and managed Medicaid). Managed Care Payer does not include any other Federal healthcare program.

IV. POLICY:

All inpatient rehabilitation services provided in a Tenet IRF shall meet the appropriate medical necessity criteria and all care provided in the IRF shall be reasonable and necessary as it applies to decisions for admission, continued stay and determination of the timing for discharge.
V. PROCEDURE:

A. Admission Criteria

Patients must meet the stated criteria to be admitted to Tenet IRF. All inpatient rehabilitation services provided in a Tenet IRF shall meet the appropriate medical necessity criteria as set forth in this policy.

For patients who are covered by any payer other than traditional Medicare (e.g., a Managed Care Payer, other non-Medicare Federal healthcare programs, etc.) the IRF Program Director is responsible for ensuring that the IRF adheres to all of the applicable non-Medicare payer’s requirements including without limitation, preauthorization or pre-certification requirements, coverage criteria and billing requirements. These requirements may be specified in a Managed Care Agreement, program manuals for non-Medicare Federal health care program payers and other written or verbal instructions from the payer. The IRF Program Director is responsible for understanding those requirements and ensuring the adherence to these requirements by the IRF. In addition, those who submit claims to the payer on behalf of the IRF (e.g. Conifer) shall also ensure that they understand the requirements so the billing for care is accurate. Program management and billing personnel are expected to confer during the course of the patient’s stay as a means to ensure that billing is accurate.

Tenet IRF programs shall comply with all documentation requirements described in Attachment A.

1. The patient must have significant functional deficits, as well as documented medical and nursing needs, regardless of diagnosis, that require:

   a. Close medical supervision by a physiatrist or other physician qualified by training and experience in rehabilitation.

   b. 24-hour availability of nurses skilled in rehabilitation; and

   c. Treatment by multiple other licensed rehabilitation professionals (such as physical therapists, occupational therapists, speech language pathologists, and prosthetics/orthotics) as needed in a time-intensive and medically-coordinated program.
2. The medical stability of the patient and management of medical or surgical co-morbidities are considered to be:
   a. Manageable in the rehabilitation program; and
   b. Permit simultaneous participation in the rehabilitation program.

3. The patient presents as capable of fully participating in the inpatient rehabilitation program as evidenced by:
   a. A mental status demonstrating responsiveness to verbal, visual, and/or tactile stimuli and ability to follow simple commands.
   b. An ability to actively participate in an intensive level of rehabilitation (generally defined as 3 hours of therapy per day five days per week).

4. The patient has objective and measurable functional goals identified to warrant the admission that:
   a. Offer practical improvements; and
   b. Are expected to be achieved within a reasonable period of time

5. The patient has a reasonable probability of benefiting from the inpatient rehabilitation program.

6. The patient, in most circumstances, has a home and available family or care providers such that there is a likelihood of returning the patient to home or a community-based environment.

While Tenet sets forth the criteria for admission for its IRF programs, it does so to comply with regulatory requirements. Medical Directors and other personnel are accountable for documenting justification for the admission within the medical record. The Medical Director or other admitting rehab physicians are supported but held accountable to make the final decisions for admission to the IRF programs. It is therefore incumbent upon them to detail the level of functional and medical severity that supports the admission and the decision to care for the patient in the IRF setting.
B. Exclusions to Admission

1. The following medical conditions are excluded from IRF admission:
   a. Ventilator dependent patients;
   b. Presence of an untreated psychiatric disorder as a primary diagnosis or on suicidal precautions and/or unstable psychiatric condition;
   c. Profound anemia with declining Hemoglobin/Hematocrit of unknown etiology;
   d. Patients with chest tubes;
   e. Active TB or any other respiratory infection requiring respiratory isolation;
   f. Patients with a Rancho Los Amigos Head Injury scale score 1 – 3; and
   g. Patients on cardiac medication drips (e.g., dopamine).

2. The following medical conditions may be admitted upon Medical Director approval with an established plan of care that is evidenced in the History and Physical.
   a. Patients with a terminal illness and a prognosis less than six months;
   b. Patients with MRSA, VRE, C-Diff and other infections requiring contact isolation;
   c. Individuals requiring telemetry, if telemetry is available in the IRF;
   d. Patients on neutropenic precautions – WBC <4.0;
   e. Patients with a Rancho Los Amigos Head Injury scale score 4;
   f. Patients requiring radiation and/or chemotherapy;
   g. Spinal cord injury patients with strength less than 2/5 that are not receiving low molecular weight heparin or have not had placement of a venous filter catheter; and
h. Patients under 18 years of age.

The Medical Director may make admitting decisions on other cases not listed here provided that the physician determines that the patient care requirements are within the experience level of the treatment team, the needed resources can be obtained, and there is an established plan of care as evidenced in the History and Physical.

C. Continued Stay Criteria

Acute inpatient rehabilitation requires evidence of an interdisciplinary, coordinated rehabilitation team review at least once weekly, which should document ALL of the following:

1. Evidence of active participation in a multi-disciplinary rehabilitation program; AND

2. Evidence of progress toward stated goals documented by objective functional measures; AND

3. Identification of range and severity of the individual’s problems, including medical status and stability, self-care, mobility, psychological status, and communication status; AND

4. Consideration of special equipment needs when appropriate; AND

5. Goal modification based on current status, progress, and potential for improvement; AND

6. Projected length of stay and discharge/disposition planning; AND

7. Status of training provided to the patient and family members/caregivers by various rehabilitation disciplines regarding post discharge care; AND

8. Identification of barriers to progress, including any medical complications likely to impede progress; AND

9. Information regarding the status of the underlying medical condition

In general, the documentation should provide evidence that the individual is benefiting from the program, that there is progress towards reasonable goals, and that acute inpatient rehabilitation continues to be the most appropriate level of care.
D. Discharge Criteria

Discharge from acute inpatient rehabilitation is appropriate if one or more of the following is present.

1. Treatment goals necessitating the inpatient setting were achieved; OR
2. Absence of participation in an interdisciplinary rehabilitation program; OR
3. The individual has limited potential for recovery (e.g. the individual’s functional status has remained unchanged or additional functional improvement appears unlikely within a reasonable time frame; OR
4. Individual is unable to actively participate in an intensive rehabilitation program (most typically defined as at least 3 hours of multidiscipline therapy per day, at least 5 days per week): OR
5. The overall medical status is such that no further progress is anticipated or only minimal gains that could be expected to be attained with either less intensive therapy or regular daily activities.

E. Responsible Person

The IRF Program Director is responsible for ensuring that all professional level rehabilitation personnel inclusive of the Medical Director adhere to the requirements of this policy. If the IRF Program Director is unable to create adherence to this policy, the IRF Program Director shall immediately report the non-adherence to this policy to the Hospital Compliance Officer.

F. Auditing and Monitoring

Tenet’s Audit Services Department shall monitor adherence to this policy during its full scope audits.

G. Enforcement

All employees whose responsibilities are affected by this policy are expected to be familiar with the basic procedures and responsibilities created by this policy. Those employees who fail to comply with this policy will be subject to appropriate performance management pursuant to all applicable policies and procedures, up to and including termination. Such performance improvement may also include modification of compensation, including any merit or discretionary compensation awards, as allowed by applicable law.
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VI. REFERENCES:

- Regulatory Compliance Policy COMP-RCC-4.18, Clinical Determination of Appropriate Patient Status

- Medicare Benefit Policy Manual, Ch. 1-110-Inpatient Hospital Services Covered Under Part A – Inpatient Rehabilitation Services

- 42 CFR § 412.23 (b)

- 42 CFR § 412.25 (a)(2)

- 42 CFR § 412.29

- 42 CFR § 412.622 (a)(3)-(5)

- Quality, Compliance and Ethics Program Charter

- Standards for Assessing Medical Appropriateness Criteria for Admitting Patients to Rehabilitation Hospitals or Units, AMRPA

VII. ATTACHMENTS:

- Attachment A: Inpatient Rehabilitation Documentation and Billing Requirements
INPATIENT REHABILITATION DOCUMENTATION AND BILLING REQUIREMENTS

I. Medicare Coverage Criteria:

IRF care is only considered by Medicare to be reasonable and necessary if, as documented in the patient’s medical record, the patient meets the following criteria at the time of the patient’s admission to the IRF:

A. Multiple Therapy Disciplines – At the time of admission to the IRF, there shall be a reasonable expectation that the patient requires the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics). One of the therapy disciplines shall be physical or occupational therapy.

B. Intensive level of Rehabilitation Services – At the time of admission to the IRF, there shall be a reasonable expectation that the patient requires the intensive rehabilitative therapy services that are uniquely provided in an IRF.

1. “Three Hour Rule”--The generally-accepted standard by which the intensity of services is demonstrated in IRFs is by the provision of intensive therapies at least 3 hours per day at least 5 days per week. In certain well-documented cases, an intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive day period, beginning with the date of admission to the IRF, as long as the reasons for the patient’s need for this program of intensive rehabilitation are well-documented in the patient’s medical record and the overall amount of therapy can reasonably be expected to benefit the patient. In any case, the intensity of therapy shall be reasonable and necessary and shall never exceed the patient’s level of need or tolerance, or compromise the patient’s safety.

2. Start of Therapy--The required therapy treatments shall begin within 36 hours from midnight of the day of admission to the IRF. Therapy evaluations constitute the beginning of the required therapy services and may also be included in the total provision of therapies used to demonstrate the intensity of therapy service provided in an IRF.

3. Individualized Therapy--The standard of care for IRF patients is individualized (i.e. one-to-one) therapy. Group therapies serve only as an adjunct to individual therapies and may not be counted toward the requirement that patients receive at least 3 hours of intensive therapy at least 5 days per week. Group therapy is defined as either (1) a group of patients doing the same treatment with the same plan and goals or (2) overlapping treatment time of more than one patient to one therapist. In those instances in which group therapy is used on a limited basis, the rationale that justifies group therapy shall be specified in the patient’s medical record at the IRF.

4. Brief Exception Policy--If an unexpected clinical event occurs during the course of the patient’s IRF stay that limits the patient’s ability to participate in the therapy program for a brief period not to exceed 3 consecutive days (e.g. extensive diagnostic tests off
C. Ability to Actively Participate in Intensive Rehabilitation Therapy – at the time of admission to the IRF, there shall be a reasonable expectation that the patient can actively participate in, and significantly benefit from, the intensive rehabilitation therapy program. The information in the preadmission screening, the post-admission physician evaluation, the overall plan of care, and the admission orders shall clearly document this expectation.

1. Significant Benefit/Measurable Practical Improvement--a patient can only be expected to benefit significantly from an intensive rehabilitation therapy program provided in the IRF if the patient’s medical record indicates a reasonable expectation that a measurable, practical improvement in the patient’s functional condition can be accomplished within a predetermined and reasonable period of time. The patient’s medical record shall document both the nature and degree of expected improvement and the expected length of time to achieve the improvement.

2. Functional Improvement--the IRF medical record shall also demonstrate that the patient is making functional improvements that are ongoing and sustainable, as well as of practical value, measured against his/her condition at the start of treatment. The patient’s treatment goals and achievements during an IRF admission are expected to reflect significant and timely progress toward the end goal of returning to the home or community-based environment.

3. Discharge Planning--discharge planning is an integral part of any rehabilitation program and shall begin upon the patient’s admission to the IRF. An extended period of time for discharge from the IRF would not be reasonable and necessary after established goals have been reached or the determination has been made that further progress is unlikely.

D. Physician Supervision – at the time of admission to the IRF, there shall be a reasonable expectation that the patient’s medical management and rehabilitation needs require an inpatient stay and close physician involvement.

1. Face-to-Face Visits--close physician involvement is demonstrated by documented face-to-face visits at least 3 days per week from a rehabilitation physician or other licensed treating physician with specialized training and experience in rehabilitation throughout the patient’s stay in the IRF. The purpose of the face-to-face visits is to assess the patient both medically and functionally with an emphasis on the important interactions between the patient’s medical and functional goals and progress, as well as to modify the course of treatment as needed to maximize the patient’s capacity to benefit from the rehabilitation process. The required rehabilitation visits shall be documented in the patient’s medical record.
2. Non-Rehabilitation Physicians--Other physician specialties may treat and visit the patient, as needed; however, these visits do not count toward the rehabilitation physician requirements described above.

3. Physician Progress Notes--physician progress notes shall be legible and include documentation of medical issues, consultant coordination and functional status. At a minimum the physician progress notes shall reflect active and ongoing rehabilitation management and document:

   (a) Coordination of medical management as it impacts the rehabilitation process i.e.; coordination of consultant services and communication with referring and primary care physicians

   (b) Coordination of the rehabilitation team process

   (c) Participation in family conference

   (d) Participation in team conference

   (e) Revisions to the anticipated plan of care

   (f) Determination of impairment/functional status

   (g) Ongoing assessment of rehabilitation services

   (h) Assessment and/or management of the plan as it relates to the rehabilitation process

   (i) Assessment of discharge status and/or needs i.e.; follow-up

E. Interdisciplinary Team Approach to the Delivery of Care--at the time of admission to the IRF, the patient shall require an intensive and coordinated interdisciplinary approach to providing rehabilitation. The documentation in the patient’s medical record shall indicate that the complexity of the patient’s nursing, medical management and rehabilitation needs require an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.

1. Required Disciplines--the interdisciplinary team shall document participation by professionals from the following disciplines (each of whom shall have current knowledge of the patient as documented in the medical record):

   (a) rehabilitation physician with specialized training and experience in rehabilitation services

   (b) a registered nurse with specialized training and experience in rehabilitation services

   (c) a social worker or a case manager (or both)

   (d) a licensed or certified therapist from each therapy discipline involved in treating the patient
2. Rehabilitation Physician--the interdisciplinary team shall be led by a rehabilitation physician who is responsible for making the final decisions regarding the patient’s treatment in the IRF. This physician shall document concurrence with all decisions made by the interdisciplinary team at each meeting. A physician extender, NP or PA may participate in Team Conference; however, the requirement is not met if the physician is not present and participating in the team conference.

3. Team Conferences--the team conferences shall be held a minimum of once per week and focus on:

   (a) Assessing the individual’s progress towards the rehabilitation goals.

   (b) Considering possible resolutions to any problem that could impede progress towards the goals.

   (c) Reassessing the validity of the rehabilitation goals previously established.

   (d) Monitoring and revising the treatment plan as needed.

4. All treating professionals from the required disciplines must attend every meeting or, in the infrequent case of an absence, be represented by another person of the same discipline who has current knowledge of the patient.

5. Documentation of each team conference shall include the names and professional designations of the participants in the team conference as demonstrated by the signature of each of the team members present at the team conference.

6. The occurrence of the team conference and the decisions made during the team conferences, such as those concerning discharge planning and the need for any adjustment in goals or in the prescribed treatment program, shall be recorded in the patient’s medical record.

II. Documentation and Claim Submission Requirements:

For traditional Medicare beneficiaries, prior to billing a claim for services to Medicare, the IRF Director shall confirm that the medical record contains documentation that meets the coverage criteria established by the Medicare Benefit Policy Manual, Chapter 1, Section 110 and supported by regulatory changes found in 42 C.F.R. Section 412.622 for inpatient rehabilitation services provided in inpatient rehabilitation facilities and all of the requirement of this policy. The IRF Program Director is responsible for establishing an oversight process at the IRF to ensure that no claim is submitted to the Medicare program unless all of the requirements of this policy are met and that no claim is submitted to any other payer unless all of the requirements set forth by that payer are met.

Medical Record documentation requirements referenced in the following sections are applicable to all patients regardless of payer.
A. Required Preadmission Screening

1. Purpose--a preadmission screening is an evaluation of the patient’s condition and need for rehabilitation therapy and medical treatment. The preadmission screening documented in the patient’s medical record serves as the primary documentation by the IRF clinical staff of the patient’s status prior to admission and of the specific reasons that led to the conclusion that the IRF admission would be reasonable and necessary.

2. Timing of Preadmission Screening--all patients shall receive a preadmission screening that is conducted by licensed or certified clinicians within 48 hours immediately preceding the IRF admission. A preadmission screening that includes all the required elements, but that is conducted more than 48 hours immediately preceding the IRF admission, is acceptable as long as an update to the original screening is conducted in person or by telephone to document the patient’s medical and functional status within the 48 hours immediately preceding the IRF admission. The documentation shall be detailed and comprehensive. The review shall be done in person or through a review of the patient’s acute care hospital medical record (either paper or electronic), as long as those medical records contain the necessary assessments to make a reasonable determination. A preadmission screening conducted entirely by telephone will not be acceptable without transmission of the patient’s medical record from the referring hospital to the IRF and a timely review of those records by licensed or certified clinical staff in the IRF.

3. Documentation--all preadmission screening documentation (including documents transmitted from the referring hospital or other prior inpatient hospital stay) shall be retained in the patient’s medical record at the IRF.

4. Licensed or Certified Clinician--referral and preadmission screening documentation shall be completed by licensed/certified clinicians who are permitted to perform assessments within their state scope of practice, have evidence of training and competency to perform preadmission screenings, and be approved by the rehabilitation physician. Individuals, regardless of clinical qualifications, assigned to business development functions such as marketing and community relations will not conduct clinical preadmission screenings for the purpose of determining if the admission criteria are met for the inpatient rehabilitation program.

5. The data collections process may be completed by an assistant (PTA, COTA or LVN/LPN, etc.). The assistant may only perform data collection and chart review activities for the purpose of providing information used by the clinician performing the preadmission screening. The qualified clinician conducting and documenting the preadmission screening shall review and approve any data collected by an assistant. The assistant may not visit with the patient and/or family, perform patient assessments, document on the preadmission screening form, or make recommendations regarding the pre-admission assessment.
6. Content—the Preadmission screening shall clearly document the following:

(a) Indicate the patient’s prior level of function (prior to the event or condition that led to the patient’s need for intensive rehabilitation therapy).

(b) Expected level of improvement and the expected length of time necessary to achieve that level of improvement.

(c) An evaluation of the patient’s risk for clinical complications.

(d) The conditions that caused the need for rehabilitation and the treatments needed (i.e. physical therapy, occupational therapy, speech-language, or prosthetic s/orthotics).

(e) Expected frequency and duration of treatment in the IRF.

(f) A reasonable expectation that the patient will actively participate in, and benefit significantly from, at least 3 hours of therapy per day at least 5 days per week.

(g) A reasonable expectation that a measurable, practical improvement in the patient’s functional condition can be accomplished within a pre-determined and reasonable period of time.

(h) Anticipated discharge destination and any anticipated post-discharge treatments.

7. Rehabilitation Physician Review—For Medicare Part A patients, all findings of the preadmission screening shall be conveyed to a rehabilitation physician prior to the IRF admission. In addition, the rehabilitation physician shall document that he or she has reviewed and concurs with the findings and results of the preadmission screening prior to the IRF admission.

(a) Trial Admissions—“Trial” IRF admissions, during which patients were sometimes admitted to IRFs for 3 to 10 days to assess whether the patients would benefit significantly from treatment in the IRF setting, are no longer considered reasonable and necessary.

B. Post Admission Physician Evaluation

1. A Post Admission evaluation of the patient shall be performed by a rehabilitation physician (with input from the interdisciplinary team) within the first 24 hours of admission to the IRF. The purpose of the post admission physician evaluation is to document the patient’s status on admission to the IRF, compare it to that noted in the preadmission screening documentation, and begin the development of the patient’s overall plan of care and course of treatment. The post admission physician evaluation shall identify any relevant changes that may have occurred since the preadmission screening and shall include a documented history and physical exam, as well as a review of the patient’s prior and current medical and functional conditions and comorbidities.
2. Physician documentation in the History and Physical/Post Admission Evaluation at a minimum shall include:

(a) Medical history
(b) Date of onset
(c) Results of physical exam
(d) Results of neurological exam
(e) Prior Level of Function
(f) Current level of function
(g) Current medical status
(h) Comparison to pre-admit and relevant changes
(i) Comorbidities impacting function
(j) Family/social history
(k) Barriers to discharge
(l) Medical plan
(m) Rehabilitation plan
(n) General rehabilitation goals
(o) Estimated Length of Stay
(p) Etiologic diagnosis/impairment group

3. If the post-admission physician evaluation indicates that the patient is not an appropriate candidate for IRF care due to a marked improvement in the patient’s functional ability or an inability to meet the demands of the IRF rehabilitation program, the IRF shall immediately begin the process of discharging the patient to another setting. Medicare will allow the patient to continue treatment until another level of care is found; however, any IRF services provided after the 3rd day following the patient admission are not considered reasonable and necessary.

C. Required Individualized Overall Plan of Care

1. Plan of Care--in order for the IRF admission to be considered reasonable and necessary, the overall plan of care shall be completed by the rehabilitation physician within the first 4 days of the IRF admission, and it shall support the determination that the IRF admission is reasonable and necessary. The plan of care shall be updated at least weekly by each
discipline involved in the care of the patient and be maintained in the patient’s medical record.

2. Content—the overall plan of care shall be based on information from the preadmission screen, the post-admission physician evaluation, and information garnered from the individualized therapy assessments. To support the medical necessity of the admission, the plan of care shall detail:

(a) the patient’s medical prognosis

(b) the anticipated interventions (including intensity, duration, and frequency as described below)

(c) functional outcomes

(d) estimated length of stay

(e) the discharge destination from IRF stay

3. Anticipated Therapy Interventions—the anticipated interventions detailed in the overall plan of care shall include the expected intensity (meaning number of hours per day), frequency (meaning number of days per week), and duration (meaning the total number of days during the IRF stay) of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies required by the patient during the IRF stay. These expectations for the patient’s course of treatment shall be based on consideration of the patient’s impairments, functional status, complicating conditions, and any other contributing factors.

4. Sole Responsibility of Rehabilitation Physician—Whereas the individual assessments of appropriate clinical staff will contribute to the information contained in the overall plan of care, it is the sole responsibility of a rehabilitation physician to integrate the information that is required in the overall plan of care and to document it in the patient’s medical record at the IRF.

5. Discrepancies—in the unlikely event that the patient’s actual length of stay and/or expected intensity, frequency, and duration of physical, occupational, speech-language pathology, and prosthetics/orthotic therapies in the IRF differ significantly from the expectations indicated in the overall plan of care, the reasons for the discrepancies shall be documented in detail in the patient’s medical record.

D. Admission Orders

1. Physician Orders—a physician shall generate admission orders for the patient’s care at the time of the patient’s admission to the IRF. Physician orders shall be documented for Evaluation and Treatment of patients for each discipline that provides services for a patient. These orders shall be documented prior to the initiation of evaluation and treatment for therapy.
2. Clarification Orders--therapy clarification orders shall be obtained from the physician and are ongoing throughout the course of treatment.

3. Content of Clarification Orders--clarification orders shall define treatment modalities, frequency (number of days per week which cannot be defined in ranges such as “1-2 days per week”), intensity (number of treatments per day – which cannot be defined by a number of minutes or hours), and duration (number of weeks of therapy – which cannot be defined by ranges such as 2 – 3 weeks). Clarification orders shall be documented directly by the physician or by the responsible therapist. If completed by the therapist they shall follow the hospital’s process for telephone and/or verbal orders. Only nursing may obtain physician verbal orders for all therapy disciplines. Clarification orders shall be approved by the physician (verbal, telephone, or fax) prior to the initiation of therapy. Clarification orders shall be renewed before or at the time of expiration for continuation of the treatment ordered. The Interdisciplinary Plan of Care can serve this function provided all elements are met.

E. Inpatient Rehabilitation Facility Patient Assessment Instrument

The IRF shall maintain the IRF patient assessment instrument (IRF-PAI) forms in the patient’s medical record as required by Medicare. The information in the IRF-PAI shall correspond with all of the information provided in the patient’s medical record.

F. Therapy Documentation Requirements

Therapy documentation shall demonstrate the need for a qualified professional to provide for services that are of such a level of complexity and sophistication that the services can be safely and effectively performed only by or under the supervision of a qualified professional therapist.

1. Therapy Initial Assessment shall provide:

(a) Assessment of functional status including physical status, ADL function and cognitive functions such as memory, judgment or problem solving.

(b) Identification of problem areas to be addressed by involved disciplines.

(c) Identification of anticipated goals in measurable terms – long and short term goals.

(d) Identification of interventions to be utilized to progress towards identified goals.

2. Therapy Treatment Notes shall provide:

(a) Daily documentation of exact (not rounded) time spent with each discipline included in the three hour requirement.

(b) Identification of treatment interventions utilized to progress toward anticipated goals.
(c) Documentation of exceptions to the “three hour rule” *i.e.*, medical complications.

(d) Ongoing documentation of an individual’s progress.

3. Therapy Progress Notes shall be documented weekly, at a minimum, and shall provide:

   (a) Ongoing assessment of current treatment plan and progress towards/revisions to goals in measureable terms based on progress.

   (b) Identification of any barriers impeding progress.

   (c) Educational interventions to patient and/or family.

4. Discharge status:

   Documentation shall reflect current discharge status *i.e.*, DME needs, current level of function and future rehabilitation needs throughout the course of treatment.

III. Medicare PPS Exempt Status:

A. In order to maintain PPS Exempt Status, at least 60 percent of admissions to the IRF must fall within the following diagnostic categories:

1. Stroke

2. Spinal Cord Injury

3. Congenital Deformity

4. Amputation

5. Major Multiple Trauma

6. Fracture Femur (hip fracture)

7. Brain Injury

8. Neurological Disorders (*including* multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson’s disease)

9. Burns

10. Active, polyarticular rheumatoid arthritis, psoriatic arthritis, and seronegative arthropathies resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or
that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

11. Systemic vasculidities with joint inflammation, resulting in significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation.

12. Severe or advanced osteoarthritis (osteoarthrosis or degenerative joint disease) involving two or more major weight bearing joints (elbow, shoulders, hips, or knees, but not counting a joint with a prosthesis) with joint deformity and substantial loss of range of motion, atrophy of muscles surrounding the joint, significant functional impairment of ambulation and other activities of daily living that have not improved after an appropriate, aggressive, and sustained course of outpatient therapy services or services in other less intensive rehabilitation settings immediately preceding the inpatient rehabilitation admission or that result from a systemic disease activation immediately before admission, but have the potential to improve with more intensive rehabilitation. (A joint replaced by prosthesis no longer is considered to have osteoarthritis, or other arthritis, even though this condition was the reason for the joint replacement.)

13. Knee or hip joint replacement, or both, during an acute hospitalization immediately preceding the inpatient rehabilitation stay, plus one or more of the following specific criteria.

   (a) The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the IRF admission.

   (b) The patient is extremely obese with a Body Mass Index of at least 50 at the time of admission to the IRF.

   (c) The patient is age 85 or older at the time of admission to the IRF.

B. Patients admitted for inpatient rehabilitation for a condition that is not one of the 13 conditions listed above may be counted towards the applicable compliance percentage if:

1. The patient has a co-morbidity that falls in one of the CMS 13 conditions specified above; and

2. the co-morbidity has caused significant decline in functional ability in the individual such that, even in the absence of the admitting condition, the individual would require the intensive rehabilitation treatment that is unique to inpatient rehabilitation and cannot be appropriately performed in another care setting.