

Medicare Benefit Policy Manual

Chapter 1 - Inpatient Hospital Services Covered Under Part A

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pregnancy itself that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

NOTE: The "G7" modifier must be used with the following CPT codes in order for these services to be covered when the pregnancy resulted from rape or incest, or the pregnancy is certified by a physician as life threatening to the mother:

59840	59841	59850
59851	59852	59855
59856	59857	59866

100 - Treatment for Infertility

(Rev. 1, 10-01-03)

A3-3101.13

Effective for services rendered on or after January 15, 1980, reasonable and necessary services associated with treatment for infertility are covered under Medicare. Like pregnancy (see §80 above), infertility is a condition sufficiently at variance with the usual state of health to make it appropriate for a person who normally would be expected to be fertile to seek medical consultation and treatment. A/B MACs (A) should coordinate with QIOs to see that utilization guidelines are established for this treatment if inappropriate utilization or abuse is suspected.

110 - Inpatient Rehabilitation Facility (IRF) Services

(Rev. 10892; Issued: 08-06-21; Effective: 11-08-21; Implementation: 11-08-21)

The inpatient rehabilitation facility (IRF) benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care.

The IRF benefit is not to be used as an alternative to completion of the full course of treatment in the referring hospital. A patient who has not yet completed the full course of treatment in the referring hospital is expected to remain in the referring hospital, with appropriate rehabilitative treatment provided, until such time as the patient has completed the full course of treatment. Though medical management can be performed in an IRF, patients must be able to actively participate in and benefit from the intensive rehabilitation therapy program provided in IRFs in order *for an IRF claim to be considered reasonable and necessary, in accordance with 42 CFR § 412.622(a)(3)(ii). Therefore, patients who are not able to actively participate in and benefit from the intensive rehabilitation therapy services because they are still completing their course of treatment in the referring hospital should remain in the referring hospital until they are able to do so.*

Conversely, the IRF benefit is not appropriate for patients who have completed their full course of treatment in the referring hospital, but do not require intensive rehabilitation. Medicare benefits are available for such patients in a less-intensive setting.

IRF care is only considered by Medicare to be reasonable and necessary under 1862(a)(1)(A) of the Social Security Act if the patient meets all of the requirements outlined in 42 CFR § 412.622(a)(3), (4), and (5). This is true regardless of whether the patient is treated in the IRF for 1 or more of the 13 medical conditions listed in 42 CFR § 412.29(b)(2) or not. Medicare requires determinations of whether IRF stays are reasonable and necessary to be based on an assessment of each beneficiary's individual care needs.

For detailed guidance on the required qualifications of a therapist, required skills of a therapist, and medically necessary and appropriately documented therapy services, see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, sections 220 and 230. The policies in those sections describe a standard of care that should be consistent throughout the therapy disciplines, regardless of the setting of care.

110.1 - Documentation Requirements

(Rev. 10892; Issued: 08-06-21; Effective: 11-08-21; Implementation: 11-08-21)

Part A/B Medicare Administrative Contractors (MACs) (A) must consider completion of the requirements at 42 CFR § 412.622(a)(3), (4), and (5) in a patient's IRF medical record when determining whether an IRF admission was reasonable and necessary.

110.1.1 - Required Preadmission Screening

(Rev. 10892; Issued: 08-06-21; Effective: 11-08-21; Implementation: 11-08-21)

In accordance with 42 CFR § 412.622(a)(4)(i) a preadmission screening is an evaluation of the patient's condition and need for rehabilitation therapy and medical treatment that must be conducted by licensed or certified clinician(s) within the 48 hours immediately preceding the IRF admission. A preadmission screening that includes all of the required elements, but that is conducted more than 48 hours immediately preceding the IRF admission, will be accepted as long as an update is conducted in person or by telephone to document the patient's medical and functional status within the 48 hours immediately preceding the IRF admission in the patient's medical record at the IRF. The preadmission screening in the patient's IRF medical record serves as the primary documentation by the IRF clinical staff of the patient's status prior to admission and of the specific reasons that led the IRF clinical staff to conclude that the IRF admission would be reasonable and necessary. As such, IRFs must make this documentation detailed and comprehensive.

In accordance with 42 CFR § 412.622(a)(4)(i)(B) the preadmission screening documentation must indicate the patient's prior level of function (prior to the event or condition that led to the patient's need for intensive rehabilitation therapy), expected

level of improvement, and the expected length of time necessary to achieve that level of improvement. It must also include an evaluation of the patient's risk for clinical complications, the conditions that caused the need for rehabilitation, the treatments needed (i.e., physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), *and* anticipated discharge destination.

If the patient is being transferred from a referring hospital, the preadmission screening *could either* be done in person or through a review of the patient's medical records from the referring hospital (either paper or electronic format), as long as those medical records contain the necessary assessments to make a reasonable determination. However, a preadmission screening conducted entirely by telephone should generally include transmission of the patient's medical records from the referring hospital to the IRF and a review of those records by licensed or certified clinical staff *member* in the IRF *to ensure it includes a detailed and comprehensive review of the patient's condition and medical history in accordance with 42 CFR § 412.622(a)(4)(i)(B)*.

The IRF *should develop* a thorough preadmission screening process for patients admitted to the IRF from the home or community-based environment, which *should ensure that patient preadmission screenings* include all of the required elements described in *42 CFR § 412.622(a)(3), (4), and (5)*. However, such admissions may not necessarily involve the use of medical records from a prior hospital stay in another inpatient hospital setting unless such records are pertinent to the individual patient's situation.

Individual elements of the preadmission screening may be evaluated by any clinician or group of clinicians designated by a rehabilitation physician, as long as the clinicians are licensed or certified to perform the evaluation. Although clinical personnel are required to evaluate the preadmission screening information *in accordance with 42 CFR § 412.622(a)(4)(i)*, each IRF may determine its own processes for collecting and compiling the preadmission screening information. The focus of the review of the preadmission screening information will be on its completeness, accuracy, and the extent to which it supports the appropriateness of the IRF admission decision, not on how the process is organized.

The "rehabilitation physician" need not be a salaried employee of the IRF, but must be a licensed physician *who is determined by the IRF to have* specialized training and experience in *inpatient* rehabilitation, *in accordance with 42 CFR § 412.622(c)*. For ease of exposition throughout this document, this physician will be referred to as a "rehabilitation physician".

All findings of the preadmission screening *should* be conveyed to a rehabilitation physician prior to the IRF admission. *Additionally, in accordance with 42 CFR § 412.622(a)(4)(i)*, the rehabilitation physician must document that he or she has reviewed and concurs with the findings and results of the preadmission screening prior to the IRF admission.

All preadmission screening documentation (including documents transmitted from the referring hospital or other prior inpatient hospital stay, if applicable) must be retained in

the patient's medical record at the IRF *per the regulation at 42 CFR § 412.622(a)(4)(i)*.

110.1.2 - Required Post-Admission Physician Evaluation

(Rev. 10892; Issued: 08-06-21; Effective: 11-08-21; Implementation: 11-08-21)

The post-admission physician evaluation documentation requirement, previously required pursuant to 42 CFR § 412.622(a)(4)(ii), was removed in the FY 2021 IRF PPS Final Rule (85 FR 48424). However, the history and physical is still required under the Conditions of Participation at 42 CFR § 482.24(c)(4)(i)(A).

110.1.3 - Required Individualized Overall Plan of Care

(Rev. 10892; Issued: 08-06-21; Effective: 11-08-21; Implementation: 11-08-21)

In accordance with 42 CFR § 412.622(a)(4)(ii), information from the preadmission screening and other information garnered from the assessments of all therapy disciplines involved in treating the patient and other pertinent clinicians, *must* be synthesized by a rehabilitation physician to support a documented overall plan of care. The overall plan of care *should generally* detail the patient's medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRF stay, thereby supporting the medical necessity of the admission. The anticipated interventions detailed in the overall plan of care *should generally* include the 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 *should generally* be based on consideration of the patient's impairments, functional status, complicating conditions, and any other contributing factors.

Whereas the individual assessments of appropriate clinical staff will contribute to the information contained in the overall plan of care, the rehabilitation physician *is responsible (in accordance with 42 CFR § 412.622(a)(4)(ii)) for developing the overall plan of care with input from the interdisciplinary team.*

In accordance with 42 CFR § 412.622(a)(4)(ii), in order for the IRF admission to be considered reasonable and necessary, the overall plan of care must be completed within the first 4 days of the IRF admission; it must support the determination that the IRF admission is reasonable and necessary; and it must be retained in the patient's medical record at the IRF.

While CMS believes that it may be good practice to conduct the first interdisciplinary team meeting within the first 4 days of admission to develop the overall individualized plan of care, CMS believes that there may be other ways of developing the overall individualized plan of care. Thus, IRFs may develop this required documentation using whatever internal processes they believe are most appropriate, *provided that the documentation fulfills all relevant regulatory requirements.*

110.1.4 - Required Admission Orders

(Rev. 10892; Issued: 08-06-21; Effective: 11-08-21; Implementation: 11-08-21)

At the time that each Medicare Part A fee-for-service patient is admitted to an IRF, a physician must generate admission orders for the patient's care *as per the requirements at 42 CFR § 482.12(c)(2), § 482.24(c), and § 412.3*. These admission orders *should generally* be retained in the patient's medical record at the IRF.

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

(Rev. 10892; Issued: 08-06-21; Effective: 11-08-21; Implementation: 11-08-21)

As per the requirements at 42 CFR § 412.606(b), the IRF patient assessment instrument (IRF-PAI) forms should generally be included in the patient's medical record at the IRF (either in electronic or paper format).

110.2 - Inpatient Rehabilitation Facility Medical Necessity Criteria

(Rev. 10892; Issued: 08-06-21; Effective: 11-08-21; Implementation: 11-08-21)

In order for IRF care to be considered reasonable and necessary, the documentation in the patient's IRF medical record (which must include the preadmission screening described in section 110.1.1, the overall plan of care described in section 110.1.3, and the admission orders described in section 110.1.4) must demonstrate a reasonable expectation that the following criteria were met at the time of admission to the IRF. *Certain exceptions to these requirements may apply due to conditions arising during the Public Health Emergency defined in 42 CFR § 400.200. These exceptions are described further in Section 110.2.6 of this manual.*

1. The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy.
2. The patient must generally require an intensive rehabilitation therapy program, as defined in section 110.2.2. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive *calendar* day period, beginning with the date of admission to the IRF.
3. The patient must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program that is defined in section 110.2.2 at the time of admission to the IRF. The patient can only be expected to benefit significantly from the intensive rehabilitation therapy program if the patient's condition and functional status are such that the patient can reasonably be expected to make measurable improvement (that will be of practical value to improve the patient's functional capacity or adaptation to

impairments) as a result of the rehabilitation treatment, as defined in section 110.3, and if such improvement can be expected to be made within a prescribed period of time. The patient need not be expected to achieve complete independence in the domain of self-care nor be expected to return to his or her prior level of functioning in order to meet this standard.

4. The patient must require physician supervision by a rehabilitation physician, defined as a licensed physician *who is determined by the IRF to have* specialized training and experience in *inpatient* rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. *Beginning with the second week of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may conduct 1 of the 3 required face-to-face visits with the patient per week, provided that such duties are within the non-physician practitioner's scope of practice under applicable state law. In the first week of the patient's IRF stay, the rehabilitation physician is required to visit the patients a minimum of three times to ensure that the patient's plan of care is fully established and optimized to the patient's care needs in the IRF. For the second, third, fourth weeks of the stay, and beyond, CMS will continue to require Medicare fee-for-services beneficiaries in the IRFs to receive a minimum of three rehabilitation physician visits per week, but will allow non-physician practitioners to independently conduct one of these three minimum required visits per week.*
5. The patient must require an intensive and coordinated interdisciplinary approach to providing rehabilitation, as defined in section 110.2.5.

110.2.1 - Multiple Therapy Disciplines

(Rev. 112, Issued: 10-23-09, Effective: 01-01-10, Implementation: 01-04-10)

A primary distinction between the IRF environment and other rehabilitation settings is the interdisciplinary approach to providing rehabilitation therapy services in an IRF. Patients requiring only one discipline of therapy would not need this interdisciplinary approach to care. For this reason, the information in the patient's IRF medical record (especially the required documentation described in section 110.1) must document a reasonable expectation that, at the time of admission to the IRF, the patient required the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy.

110.2.2 - Intensive Level of Rehabilitation Services

(Rev. 10892; Issued: 08-06-21; Effective: 11-08-21; Implementation: 11-08-21)

A primary distinction between the IRF environment and other rehabilitation settings is the intensity of rehabilitation therapy services provided in an IRF. For this reason, the information in the patient's IRF medical record (especially the required documentation described in section 110.1) must document a reasonable expectation that at the time of admission to the IRF the patient generally required the intensive rehabilitation therapy services that are uniquely provided in IRFs. Although the intensity of rehabilitation services can be reflected in various ways, the generally-accepted standard by which the intensity of these services is typically demonstrated in IRFs is by the provision of intensive therapies at least 3 hours per day at least 5 days per week. However, this is not the only way that such intensity of services can be demonstrated (that is, CMS does not intend for this measure to be used as a "rule of thumb" for determining whether a particular IRF claim is reasonable and necessary).

The intensity of therapy services provided in IRFs could also be demonstrated by the provision of 15 hours of therapy per week (that is, in a 7-consecutive *calendar* day period starting from the date of admission). For example, if a hypothetical IRF patient was admitted to an IRF for a hip fracture, but was also undergoing chemotherapy for an unrelated issue, the patient might not be able to tolerate therapy on a predictable basis due to the chemotherapy. Thus, this hypothetical patient might be more effectively served by the provision of 4 hours of therapy 3 days per week and 1 ½ hours of therapy on 2 (or more) other days per week in order to accommodate his or her chemotherapy schedule. Thus, IRFs may also demonstrate a patient's need for intensive rehabilitation therapy services by showing that the patient required and could reasonably be expected to benefit from at least 15 hours of therapy per week (defined as a 7-consecutive *calendar* day period starting from the date of admission), as long as the reasons for the patient's need for this program of intensive rehabilitation are well-documented in the patient's IRF medical record and the overall amount of therapy can reasonably be expected to benefit the patient. Many IRF patients will medically benefit from more than 3 hours of therapy per day or more than 15 hours of therapy per week, when all types of therapy are considered. However, the intensity of therapy provided must be reasonable and necessary under section 1862(a)(1)(A) of the Act and must never exceed the patient's level of need or tolerance, or compromise the patient's safety. See below for a brief exceptions policy for temporary and unexpected events.

In accordance with 42 CFR § 412.622(a)(3)(ii), the required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF. Therapy evaluations *are generally considered to* constitute the beginning of the required therapy services. As such, they *should generally be* included in the total daily/weekly provision of therapies used to demonstrate the intensity of therapy services provided in an IRF.

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

Brief Exceptions Policy - While patients requiring an IRF stay are expected to need and receive an intensive rehabilitation therapy program, as described above, this may not be

true for a limited number of days during a patient's IRF stay because patients' needs vary over time. For example, if an unexpected clinical event occurs during the course of a patient's IRF stay that limits the patient's ability to participate in the intensive therapy program for a brief period not to exceed 3 consecutive days (e.g., extensive diagnostic tests off premises, prolonged intravenous infusion of chemotherapy or blood products, bed rest due to signs of deep vein thrombosis, exhaustion due to recent ambulance transportation, surgical procedure, etc.), the specific reasons for the break in the provision of therapy services *should generally* be documented in the patient's IRF medical record. If these reasons are appropriately documented in the patient's IRF medical record, such a break in service (of limited duration) *should generally* not affect the determination of the medical necessity of the IRF admission. Thus, A/B MACs (A) may *consider approving* brief exceptions to the intensity of therapy requirement in these particular cases if they determine that the initial expectation of the patient's active participation in intensive therapy during the IRF stay was based on a diligent preadmission screening, post-admission physician evaluation, and overall plan of care that were based on reasonable conclusions.

110.2.3 - Ability to Actively Participate in Intensive Rehabilitation Therapy Program

(Rev. 112, Issued: 10-23-09, Effective: 01-01-10, Implementation: 01-04-10)

The information in the patient's IRF medical record (especially the required documentation described in section 110.1) must document a reasonable expectation that at the time of admission to the IRF the patient's condition is such that the patient can reasonably be expected to actively participate in, and significantly benefit from, the intensive rehabilitation therapy program that is defined in section 110.2.2.

110.2.4 - Physician Supervision

(Rev. 10892; Issued: 08-06-21; Effective: 11-08-21; Implementation: 11-08-21)

A primary distinction between the IRF environment and other rehabilitation settings is the high level of physician supervision that accompanies the provision of intensive rehabilitation therapy services. For this reason, the information in the patient's IRF medical record (especially the required documentation described in section 110.1) must document a reasonable expectation that at the time of admission to the IRF the patient's medical management and rehabilitation needs require an inpatient stay and close physician involvement. Close physician involvement in the patient's care is demonstrated by documented face-to-face visits from a rehabilitation physician at least 3 days per week throughout the patient's IRF stay. *Beginning with the second week of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may conduct 1 of the 3 required face-to-face visits with the patient per week, provided that such duties are within the non-physician practitioner's scope of practice under applicable state law. In the first week of the patient's IRF stay, the rehabilitation physician is required to visit patients a minimum of three times to ensure that the patient's plan of care is fully established and optimized to the patient's care needs in the IRF. In the second, third, fourth weeks of the*

stay, and beyond, CMS will continue to require Medicare fee-for-service beneficiaries in IRFs to receive a minimum of three rehabilitation physician visits per week, but will allow non-physician practitioners to independently conduct one of these three minimum required visits per week.

The purpose of the face-to-face visits is to assess the patient both medically and functionally (with an emphasis on the important interactions between the patient's medical and functional goals and progress), as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. Other physician specialties may treat and visit the patient, as needed, more often than 3 days per week. However, the requirement for IRF physician supervision is intended to ensure that IRF patients receive more comprehensive assessments of their functional goals and progress, in light of their medical conditions, by a rehabilitation physician *who is determined by the IRF to have specialized training and experience in inpatient rehabilitation* at least 3 times per week. The required rehabilitation physician *and non-physician practitioner* visits *should generally* be documented in the patient's medical record at the IRF *per the requirements at 42 CFR § 482.24(4)(c)(vi).*

110.2.5 - Interdisciplinary Team Approach to the Delivery of Care ***(Rev. 10892; Issued: 08-06-21; Effective: 11-08-21; Implementation: 11-08-21)***

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

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

In accordance with the requirements at 42 CFR 412.622(a)(5), at a minimum, the interdisciplinary team must document participation by professionals from each of the following disciplines (each of whom must have current knowledge of the patient as documented in the medical record at the IRF):

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

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

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

Assessing the individual's progress towards the rehabilitation goals;

- Considering possible resolutions to any problems that could impede progress towards the goals;
- Reassessing the validity of the rehabilitation goals previously established; and
- Monitoring and revising the treatment plan, as needed.

A team conference may be formal or informal; however, a review by the various team members of each other's notes does not constitute a team conference. It is expected that all treating professionals from the required disciplines will be at every meeting or, in the infrequent case of an absence, be represented by another person of the same discipline who has current knowledge of the patient. Documentation of each team conference *should generally* include the names and professional designations of the participants in the team conference. *Signatures from participants of the interdisciplinary team meeting are not required other than the rehabilitation physician's concurrence as noted above.*

The occurrence of the team conferences and the decisions made during such conferences, such as those concerning discharge planning and the need for any adjustment in goals or in the prescribed treatment program, must be recorded in the patient's medical record in the IRF. The focus of the review of this requirement will be on the accuracy and quality of the information and decision-making, not on the internal processes used by the IRF in conducting the team conferences.

110.2.6 – IRF Waivers and Flexibilities During the Public Health Emergency for the COVID-19 Pandemic
(Rev. 10892; Issued: 08-06-21; Effective: 11-08-21; Implementation: 11-08-21)

Inpatient Rehabilitation Facility (IRF) Flexibilities Issued on March 30, 2020

On March 30, 2020, CMS issued the interim final rule “Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency” (CMS-1744-IFC). This interim final rule removed the IRF post-admission physician evaluation requirement in 42 CFR § 412.622(a)(4)(ii) for all Medicare Part A fee-for-service beneficiaries during the public health emergency (PHE) specified in 42 CFR 400.200. Thus, contractors shall not require documentation of post-admission physician evaluations in the IRF medical records for Medicare Part A fee-for-service beneficiaries during the PHE. As discussed in Section 110.1.2, CMS subsequently removed the post-admission physician evaluation documentation requirement entirely beginning with FY 2021 (e.g., for all IRF discharges beginning on or after October 1, 2020).

This interim final rule also revises the physician supervision requirement in 42 CFR § 412.622(a)(3)(iv) and § 412.29(e) to permit physician visits in the IRF required under these provisions to be conducted via telehealth to safeguard the health and safety of Medicare beneficiaries and the rehabilitation physicians treating them during the PHE. Contractors shall allow rehabilitation physicians to use telehealth services as defined in section 1834(m)(4)(F) of the Act to conduct the required 3 physician visits per week during the PHE for the COVID-19 pandemic.

IRF Flexibilities Issued on April 30, 2020

On April 30, 2020, CMS issued the interim final rule “Medicare and Medicaid Programs, Basic Health Program, and Exchanges; Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program” (CMS-5531-IFC). This interim final rule, codified at 42 CFR § 412.622(a)(3)(ii), waives the IRF “3-hour rule” in accordance with section 3711(a) of the CARES Act.

As a result of the “3-hour rule” waiver, contractors shall not review Medicare Part A fee-for-service beneficiaries admitted to IRFs during the PHE specified in section 1135(g)(1)(B) of the Social Security Act for compliance with 42 CFR § 412.622(a)(3)(ii). That is, Medicare Part A fee-for-service beneficiaries admitted to IRFs during the PHE do not need to receive at least 15 hours of intensive rehabilitation therapy per week. This waiver applies to all patients admitted to IRFs during the PHE.

This interim final rule also modifies the IRF coverage and classification requirements in 42 CFR § 412.29(d), (e), (h), and (i) and § 412.622(a)(3)(i), (iii) – (iv), (4), and (5) for the public health emergency (PHE) during the COVID-19 pandemic, when all of the following criteria are satisfied at the time of admission to the IRF:

- Patient is admitted to a freestanding IRF solely to alleviate acute care hospital bed capacity issues, and
- IRF is located in a state (or region, as applicable) that is experiencing a surge during the Public Health Emergency, as defined in 42 CFR § 400.200.

The regulation at 42 CFR § 412.622(c), as amended by the April 30, 2020 interim final rule, specifies that a “state (or region, as applicable) that is experiencing a surge” refers to a state region that is in Phase 1 of the presidential “Guidelines for Opening Up America Again” (<https://www.whitehouse.gov/openingamerica/>), specifically, a state (or region, as applicable) that satisfies all of the following, as determined by applicable state and local officials:

1. All vulnerable individuals continue to shelter in place.
2. Individuals continue social distancing.
3. Individuals avoid socializing in groups of more than 10.
4. Non-essential travel is minimized.
5. Visits to senior living facilities and hospitals are prohibited.
6. Schools and organized youth activities remain closed.

The evolution of the Phase 1 criteria listed above are most likely to be clearly articulated by a state’s governor. Further, contractors will need to be aware that there may not be a clearly posted phase for a state or community that aligns with the presidential “Guidelines for Opening Up America Again” cited at 42 CFR § 412.622(c).

Some of the criteria are likely to be in place across a number of phases, particularly the criteria in (i), (ii), and (iii). An example of a more complicated criteria to apply is (iv). Non-essential travel can still be minimized, even after stay at home orders are lifted in an area to allow for additional access to health care services or to allow for additional commerce (such as manufacturing) to improve the overall economic circumstances of a region or state. There may also be circumstances where beach regions, which can provide more ability for social distancing, of a state are reopening whereas more concentrated population centers remain with higher restrictions. Thus, contractors should apply the standard regionally, as applicable. Furthermore, schools and organized youth activities may be closed simply because of the time of year (for instance, during the summer months).

Additionally, contractors should recognize that, in some cases, states or regions can move to Phase 2 or Phase 3 of the plan and then return to Phase 1 if they experience another surge in cases.

In the April 30, 2020 interim final rule, CMS instructed freestanding IRFs to add the letters “DS” to the end of their unique hospital patient identification numbers (the numbers that identify the patients’ medical records in the IRF) to identify patients who are being treated in a freestanding IRF hospital solely to alleviate inpatient bed capacity in a state that is experiencing a surge during the PHE for the COVID-19 pandemic. The modifier will be used to identify those patients for whom the requirements in 42 CFR §

412.622(a)(3)(i), (iii), (iv), (4) and (5) do not apply. Thus, contractors shall not review freestanding IRF patient medical records that have “DS” at the end of their unique hospital patient identifier numbers for meeting any of the following requirements:

- Needing at least 2 forms of therapy (one of which must be physical or occupational therapy,*
- Being sufficiently stable to tolerate the IRF intensive rehabilitation therapy program,*
- Requiring close medical supervision by a rehabilitation physician, as demonstrated by at least 3 rehabilitation physician visits per week,*
- Having a preadmission screening,*
- Having an individualized overall plan of care, or*
- Having an interdisciplinary approach to care, including weekly interdisciplinary team meetings.*

In addition, as noted at 85 FR 27573 contractors shall not include freestanding IRF patient medical records that have “DS” at the end of their unique hospital patient identifier numbers when reviewing whether the IRF meets the following coverage requirements:

- Has in effect a preadmission screening procedure,*
- Has in effect a procedure for ensuring that patients receive close medical supervision by a physician,*
- Has a plan of treatment for each patient, or*
- Uses an interdisciplinary approach to care.*

Contractors shall allow freestanding IRFs to be paid at the usual IRF prospective payment amounts for these patients.

110.3 - Definition of Measurable Improvement

(Rev. 179, Issued: 01-14-14, Effective: 01-07-14, Implementation: 01-07-14)

A patient can only be expected to benefit significantly from an intensive rehabilitation therapy program provided in an IRF, as required in section 110.2.3, if the patient’s IRF medical record indicates a reasonable expectation that a measurable, practical improvement in the patient’s functional condition can be accomplished within a predetermined and reasonable period of time. In general, the goal of IRF treatment is to enable the patient’s safe return to the home or community-based environment upon discharge from the IRF. The patient’s IRF medical record is expected to indicate both the nature and degree of expected improvement and the expected length of time to achieve the improvement.

Since discharge planning is an integral part of any rehabilitation program and must 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.

For an IRF stay to be considered reasonable and necessary, the patient does not have to be expected to achieve complete independence in the domain of self-care or return to his or her prior level of functioning. However, to justify the need for a continued IRF stay, the documentation in the IRF medical record must demonstrate the patient's ongoing requirement for an intensive level of rehabilitation services (as defined in section 110.2.1) and an inter-disciplinary team approach to care (as defined in section 110.2.2). Further, the IRF medical record must 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. Since in most instances the goal of an IRF stay is to enable a patient's safe return to the home or community-based environment upon discharge, the patient's treatment goals and achievements during an IRF admission are expected to reflect significant and timely progress toward this end result. During most IRF stays, therefore, the emphasis of therapies would generally shift from traditional, patient-centered therapeutic services to patient/caregiver education, durable medical equipment training, and other similar therapies that prepare the patient for a safe discharge to the home or community-based environment.

CMS notes that as evidenced by the criteria established above, an IRF claim could never be denied for the following reasons: (1) because a patient could not be expected to achieve complete independence in the domain of self-care or (2) because a patient could not be expected to return to his or her prior level of functioning.

120 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare **(Rev. 189, Issued: 06-27-14, Effective: 05-30-14, Implementation: 06-29-14)**

Medical and hospital services are sometimes required to treat a condition that arises as a result of services that are not covered because they are determined to be not reasonable and necessary or because they are excluded from coverage for other reasons. Services "related to" non-covered services (e.g., cosmetic surgery, non-covered organ transplants, non-covered artificial organ implants, etc.), including services related to follow-up care and complications of non-covered services which require treatment during a hospital stay in which the non-covered service was performed, are not covered services under Medicare. Services "not related to" non-covered services are covered under Medicare.

Following are examples of services "related to" and "not related to" non-covered services while the beneficiary is an inpatient:

- A beneficiary was hospitalized for a non-covered service and broke a leg while in the hospital. Services related to care of the broken leg during this stay is a clear example of "not related to" services and are covered under Medicare.
- A beneficiary was admitted to the hospital for covered services, but during the course of hospitalization became a candidate for a non-covered transplant or