Policy Title:	Policy – Acute Inpatient Rehabilitation Facility (IRF)	Number & Version:	UM 01.v.4
Functional Unit:	Utilization Management	Effective Date:	5/9/2024
Policy Owner (Title):	Senior Director, Utilization Management	Page Number:	1of 9

I. POLICY STATEMENT and PURPOSE

In its administration of Medicare Advantage plans (Health Plans), the Company shall determine benefits in accordance with the requirements of the Centers for Medicare & Medicaid Services (CMS). Where CMS has established a national coverage policy on an item or service or a local Medicare contractor has done so as authorized by CMS, the Company follows the Medicare coverage policy. In the absence of fully established Medicare coverage criteria, the Company may develop and implement internal criteria based on current evidence in widely used treatment guidelines or clinical literature. Internal criteria are reviewed and approved by the Medical Management Committee and are made publicly accessible.

CMS has not established coverage criteria for Acute Inpatient Rehabilitation Facility (IRF), therefore the Company has developed and implemented this coverage policy to ensure that patients receive clinically appropriate, medically necessary care at the appropriate level, which allows for the best clinical outcome and prevents harm such as inpatient acquired illness. The purpose of this policy is to describe the circumstances under which Acute Inpatient Rehabilitation Facility admissions and continued stays would be considered medically necessary.

II. BACKGROUND

An IRF is a hospital 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 fully participate in and benefit from the intensive rehabilitation therapy program provided in IRFs to be transferred to an IRF (CMS, 2021).

III. SCOPE

This Policy applies to Acute Inpatient Rehabilitation Facility (IRF) admissions and continued stays.

IV. DEFINITIONS

IRF: According to CMS, an Inpatient Rehabilitation Facility (IRF) is "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" (CMS, 2021).

Medically Necessary – Covered Services rendered by a Health Care Provider that the Plan determines are:

1) Safe and effective
2) Not experimental or investigational
3) Appropriate for patients,
   a) including the duration and frequency that is considered appropriate for the item or service, in terms of whether it is—
      i) furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member,
      ii) furnished in a setting appropriate to the patient's medical needs and condition,
      iii) ordered and furnished by qualified personnel,
      iv) one that meets, but does not exceed, the patient's medical need; and
      v) is at least as beneficial as existing and available medically appropriate alternatives.

IV. OWNERSHIP & TRAINING

The Senior Director of Utilization Management is responsible for administration, oversight, and training regarding performance under this Policy.

V. PROTOCOLS / COVERAGE POLICY

A. IRF admission / continued stay may only be approved when the following conditions are met:
   i. Admission Orders must be written by a physician, present on admission, and retained in the IRF chart.
   ii. There must be an Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) form in the patient's medical record at the IRF (either in electronic or paper format).
   iii. A Preadmission Screening is performed within the 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, will be accepted if 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 document must contain the following and be contained in the IRF's records:
      a) 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,
      c) expected length of time necessary to achieve that level of improvement,
      d) evaluation of the patient's risk for clinical complications,

e) the conditions that caused the need for rehabilitation,
f) the treatments needed (i.e., physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), *and*
g) anticipated discharge destination.

iv. At the time of admission, the patient must meet the following criteria:
a) The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech language pathology, or prosthetics/orthotics).
b) One of the therapies must be physical or occupational therapy.
c) The intensive rehabilitation therapy program should consist of at least 3 hours of therapy per day at least 5 days per week OR at least 15 hours of intensive rehabilitation therapy within a 7 consecutive *calendar* day period, beginning with the date of admission to the IRF.
d) The patient must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program. 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) because of the rehabilitation treatment and such improvement can be expected to be made within a prescribed period. (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 to meet this standard.)
e) 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.
f) 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.
g) 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.
h) 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 1of 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.
i) For the second, third, fourth weeks of the stay, and beyond, beneficiaries in the IRFs are required to receive a minimum of three rehabilitation physician visits per week. Non-physician practitioners as described above may independently conduct **one** of these **three** minimum required visits per week.

v. A medical history and physical examination must be completed and documented no more than 30 days before or 24 hours after admission or registration. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission or registration.

vi. An Individualized Overall Plan of Care is required which consists of the following:
   a) A synthesis of the 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 documented by a rehabilitation physician.
   b) Details of the patient's medical prognosis,
      i. the anticipated interventions,
      i. functional outcomes, and
      ii. discharge destination from the IRF stay, thereby supporting the medical necessity of the admission.

vii. The anticipated interventions detailed in plan of care should generally include:
   a) the expected intensity (meaning number of hours per day),
   b) frequency (meaning number of days per week), and
   c) 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.

viii. 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 (Gov.Info, 2021).

ix. In accordance with 42 CFR § 412.622(a)(4)(ii), for the IRF admission to be considered reasonable and necessary, the overall plan of care must be:
   a) completed within the first 4 days of the IRF admission,
   b) it must support the determination that the IRF admission is reasonable and necessary, and
   c) it must be retained in the patient's medical record at the IRF (Gov.Info, 2021).

x. The required therapy treatments must begin within 36 hours from midnight of the day of admission to the IRF. Therapy evaluations are considered to constitute the beginning of the required therapy services and 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.

xi. An IRF stay will only be considered reasonable and necessary if at the time of admission 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).

a) 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.
b) 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.
c) The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals.
d) 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):
    1. A rehabilitation physician who is determined by the IRF to have specialized training and experience in inpatient rehabilitation, and
    2. a registered nurse with specialized training or experience in rehabilitation,
    3. a social worker or a case manager (or both), and
    4. a licensed or certified therapist from each therapy discipline involved in treating the patient (Gov.Info, 2021).

B. 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.
C. This physician must document concurrence with all decisions made by the interdisciplinary team at each meeting.
D. The periodic team conferences—held a minimum of once per week—must focus on:
    a) Assessing the individual's progress towards the rehabilitation goals, and
    b) considering possible resolutions to any problems that could impede progress towards the goals,
    c) reassessing the validity of the rehabilitation goals previously established, and
    d) monitoring and revising the treatment plan, as needed.
E. 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.
F. 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.

G. 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.

H. 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.

I. Continued stays in and IRF are warranted 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.

J. 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 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.

K. 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 following:
   i. the patient's ongoing requirement for an intensive level of rehabilitation services (as defined in section 110.2.1) and,
   ii. an inter-disciplinary team approach to care (as defined in this document), and
   iii. 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, and
   iv. the patient's treatment goals and achievements during an IRF admission are expected to reflect significant and timely progress toward enabling a patient's safe return to the home or community-based environment upon discharge.
   v. 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 to the home or community-based environment.

L. IRF admissions / continued stays will **NOT** be approved when:
   i. A-K above are NOT met, and/or,
   ii. patients are still completing their course of treatment in the referring hospital and who therefore are not able to participate in and benefit from the intensive rehabilitation therapy services provided in IRFs and/or,
   iii. patients who have completed their full course of treatment in the referring hospital, but do not require intensive rehabilitation.

(CMS, 2021).

VI. SUMMARY of EVIDENCE

Published evidence evaluating Inpatient Rehabilitation Facility (IRF) admissions exhibit positive outcomes for patients requiring complex nursing care, medical management, and rehabilitation needs. Evidence indicated patients treated by an interdisciplinary team in an IRF had a greater chance for positive outcomes.

VII. REGULATORY REFERENCES / CITATIONS

CMS National Coverage Determinations (NCDs)	None
CMS Local Coverage Determinations (LCDs)	None
CMS Articles	None
Medicare Benefit Policy Manual Chapter 1 - Inpatient Hospital Services Covered Under Part A	Attached
CFR 412.622 (Gov.Info, 2021)	Attached

VIII. PROFESSIONAL REFERENCES / CITATIONS

1. Centers for Medicare and Medicaid Services (CMS), Medicare Benefit Policy Manual Chapter 1 - Inpatient Hospital Services Covered Under Part A, August 6, 2021. Accessed at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf on May 9, 2024.

2. GovInfo.com, 42 CFR § 412.622 - Basis of payment. Code of Federal Regulations (annual edition). Title 42: Public Health. Subpart P: Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units. Friday, October 1, 2021. Accessed at: https://www.govinfo.gov/content/pkg/CFR-2021-title42-vol2/pdf/CFR-2021-title42-vol2-sec412-622.pdf on May 9, 2024.

IX. RELATED POLICIES / PROCEDURES

None

X. ATTACHMENTS

See Section VII.

APPROVALS:

Printed Name **Signature**

CLINICAL UM POLICY FOR COVERAGE DETERMINATION

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Senior Medical Officer, UM: Michael Fusco, MD

Corporate Chief Medical Officer (MMC Chair): Debbie Zimmerman, MD

VERSION HISTORY:

Version#	Date	Author	Purpose/Summary of Major Changes
01	09/11/2019	Bob Brault	Appropriate medical conditions for patients in an IRF taken from policy last reviewed 01/2019. Requirements for multiple therapy disciplines require in medical record described
02	03/29/2021	Julie Braundmeier	General review; no substantive changes
03	08/03/2022	Gina Vehige	General review: the Post-Admission Physician Evaluation is no longer required by CMS per Medical Policy Manual Updates of 8/6/2021; dropped list of common conditions treated in an IRF; no other substantive changes. Approved by QMMC on 11/9/2022.
04	03/22/2024	Sheila Gray / Kerrie Stehl	Addition to policy statement, reference checks; summary of evidence. Approval by MMC 5/8/2024