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BY AAPC

Eli's Rehab Report

Inpatient Insights: 3 Ways to Crank Up Your IRF's Physician Documentation

Use these tips to stay one step ahead of the new IRF coverage criteria.

As you charge full-force into 2010 tackling the new inpatient rehab facility coverage criteria, keep your physician documentation radar alert.

Putting emphasis on physician education and documentation will be critical, says **Fran Fowler, FAAHC,** managing director of Health Dimensions Group in Atlanta. And it's not just the time constraints to complete the documentation that'll prove challenging but also the documentation content. "I think all the physician documentation requirements is CMS' attempt to differentiate what happens in [inpatient] rehab versus skilled care, because skilled care doesn't really have a physician [involved in rehab]," she says.

The problem: Many IRFs will be starting one step back because "physician documentation has always been problematic," notes **Ann Lambert Kremer, OTR/L, MHSA, CPC,** with Beacon Rehab Solutions in Portland, Maine. But you can stay one step ahead with these tips.

1. Focus on the Original H&P

Physicians can improve their progress notes by documenting a patient's progress toward the outlined physician management in the original history and physical (H&P), Kremer says. She also offers the following examples to include in progress notes:

• Coordination of medical management services, for example, coordinating consultation services and communicating with referring and primary care physicians.

• Coordination of the rehab team process.

• Participation in a family conference.

• Participation in a team conference. "Simply documenting a patient's functional status is not adequate," Kremer warns. "Documentation must include decisions made during the conference," such as length of stay, discharge planning, the need to adjust goals, etc.

• Revisions to the plan of care.

• Management of the patient's pain status.

• Assessment of discharge needs.

2. Keep a Regular Account of Changes

"At least weekly, write a re-assessment that describes a patient's progress (or lack thereof) toward established goals," Kremer says. You should also include documents pertaining to the patient's medical condition.

"Discuss any changes in the treatment plan or discharge planning," Kremer adds. "The information must justify the need for continued treatment and estimate the amount of continued medically necessary rehab services needed."

Important: The new IRF coverage criteria requires a physician to visit the only patient three days per week; a physician

assistant or nurse practitioner can do the other visits, Fowler points out. "This is an excellent change for staffing purposes, but the physician must do the H&P," she says. And the attending physician must do the H&P -- not just any physician.

3. Don't Let Discharge Summaries Get Sloppy

This is a short document, but you don't want a poorly written one to snag your reimbursement chances.

Tip: Include the beginning status of the patient and any discharge status. And provide good descriptions of the patient's challenges during the rehab stay, Kremer suggests.

"If a discharge summary simply states how the patient was upon discharge, the reader cannot tell the degree of function the patient attained." Thus, justifying admission is harder.

Editor's note: CMS recently clarified some questions regarding the new IRF coverage criteria. To see updates, visit www.cms.hhs.gov/InpatientRehabFacPPS/Downloads/IRF_Coverage_Follow_Up.pdf.