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Eli's Rehab Report

Inpatient Insights: Buckle Down for a Whirlwind of IRF Admission Changes

You have your work cut out for you, but the door is open for more business.

You saw the big changes in the IRF PPS rule last summer. Now that the details are out, it's time to evaluate one of the biggest impacts on your inpatient rehab facility -- admissions.

Change Your Admission Priority

The days of massive denials targeting medical necessity will start to diminish come January 2010. "The number one criteria for admission to rehab is now functional need, and that's a tremendous change from 2004, when the number one priority was medical necessity," says **Fran Fowler, FAAHC,** managing director of Health Dimensions Group in Atlanta.

So if you're used to empty beds because you've been turning away patients who are "too well" -- and sending patients back to the hospital who are "too sick" -- expect that to change. "Under the old rule, you might have had a post-stroke patient without active comorbidities who needed rehab, and he would not have been admitted, but that person would be admitted now," Fowler explains.

Keep in mind: This doesn't mean that the 60-40 Percent Rule has changed. Sixty percent of your patients must still fall under the "13 diagnoses." The change is that you don't have to ensure your entire caseload (including the remaining 40 percent) has such a high medical need.

"So, cardiac patients who were being denied left and right now have equal footing for IRF admission as long as you operate within the 60-40 rule," Fowler says.

Think ahead: Keep your referral sources in the loop of these changes. "We just taught them to send over the medical patients, and now we have to tell them to send over other people [with a rehab necessity]," Fowler points out.

3-Hour Rule Now Cuts You Some Slack

But you'll still have your share of sicker patients as well as patients who unexpectedly can't withstand three hours of rehab five days a week. And the Centers for Medicare & Medicaid Services (CMS) changed the three-hour guideline to a rule, so there's no gray area now.

Silver lining: If your patients get sick or can't withstand the rehab, you're now allowed to spread your three hours of therapy per day over seven days, as opposed to five. So while your admissions are doing better thanks to a broader patient base, at the same time, your sicker patients will see less hospital readmissions or early discharges. All that said, "[inpatient] rehab is going to turn back into a growth industry; there's no doubt about it," Fowler cheers.

Gear Up for Lots of Paperwork

All that good news, however, doesn't come without hard work. CMS updated IRF coverage criteria in the Medicare Benefits Policy Manual, and you'll see a lot of paperwork involved to get a patient in the door and paid for.

The scoop: In Transmittal 112, CMS requires a massive preadmission screening process. The screening won't necessarily affect your number of admissions, clarifies **Angie Phillips, PT,** executive VP & COO of GlobalRehab Hospitals in Dallas. "The challenges will be to provide the screening, [followed by an] assessment and physician review, in a timely manner."

A qualified clinician must conduct a preadmission screening within 48 hours immediately preceding the IRF admission.

CMS requires the documentation of this screening to include the:

• patient's prior level of function

• expected level of improvement

• estimated length of stay to reach that level of improvement

• evaluation of the patient's risk for clinical complications

• conditions that led to the rehab need

• type of treatments/therapy disciplines needed

• expected frequency and duration of treatment in the IRF

• anticipated discharge destination

• any anticipated post-discharge treatments

• any other information relevant to the patient's care needs.

Try This for Extra Documentation Umph

Even though medical necessity isn't the number one admissions priority anymore, don't let it fall by the wayside in your documentation. Phillips suggests also highlighting the following in your preadmission screening to help justify the admission:

• the patient's prior and current level of function

• a summary of what caused the loss of function and the expected improvements or goals

• medical conditions and comorbidities that may impact the patient's rehab progress.