Eli's Rehab Report

Inpatient Insights: Heads Up: Final PPS Rule Packs a Punch for IRFs

The good news: Some hidden perks are lurking inside, too.

If you felt like a bomb dropped when you read the proposed IRF PPS rule for 2010, you'll have the same reaction to CMS' final rule. From a slew of new preadmission procedures to new care planning requirements, you have a lot to prepare for in little time.

IRF Coverage Criteria Gets Clarified

CMS has adopted a new regulatory framework that clarifies IRF coverage criteria, including provisions on patient selection and care. These will replace the prior policies, including those in HCFAR 85-2-1, the agency announced in a press release. CMS said it would draft new guidance on the coverage criteria in the Medicare Benefits Policy Manual.

Here are some highlights:

• No more than 48 hours before admission, IRF patients must undergo a preadmission screening conducted by a rehabilitation physician or qualified clinician designated by the rehabilitation physician. In the Final Rule, however, patients can get this screening before the 48-hour mark as long as the rehabilitation physician or the clinician conducts a brief in-person or phone meeting within 48 hours of admission to update the patient's medical and functional status. The physician/clinician also must document this in the patient's IRF medical record. If the preadmission screening is completed by a clinician, the rehabilitation physician must document his or her concurrence with the findings and results for admission in the patients IRF medical record.

• A specialized rehab physician must order the IRF services and is responsible for the final decisions on the patient's treatment. "CMS makes it clear that the physician has to step to the front and be very visible," observes **Fran Fowler, FAAHC,** managing director of Health Dimensions Group in Atlanta. "The physician has to sign off on all key decisions made in team meetings."

• An interdisciplinary team must coordinate the care. The team must consist of a rehabilitation physician, at least one registered nurse with experience in rehab, a social worker or case manager (or both), and a licensed or certified therapist from each therapy discipline involved in treating the patient. Also, the team must meet at least once a week, rather than once every two weeks.

• Within 24 hours of admission to the IRF, the rehab physician must do a post-admission evaluation to verify that the preadmission screening information is still accurate. CMS dropped its proposed requirement that the physician consult with the interdisciplinary team on this assessment, points out **Patricia Trela, RHIA**, director of HIM and rehabilitation services for Diskriter Inc. in Pittsburgh. "The Final Rule also specifies that therapy must be initiated within 36 hours of midnight the day of admission."

Don't miss: "Coverage criteria" is not the same as the requirements IRFs must meet to be paid under IRF PPS, such as the 60 percent rule, CMS clarified. "The coverage criteria apply to all Medicare patients in the facility without regard to whether they have one of the IRFqualifying conditions as an admitting or secondary diagnosis." Also, Medicare Advantage patients must now be reported using the IRF PAI, and these patients count toward the 60 percent threshold.

Prepare for Operational Overhaul

"IRFs should start to look at their processes and timeframes to complete the pre-admission screening, the post-admission evaluation, and the development of the individualized overall plan of care," Trela recommends.

"Develop procedures to include documentation of these items in the patient's health record."

Critical: If you've relied heavily on group therapy to meet the 3-hour rule, you're in for a shock. CMS hinted at scrutinizing group therapy in the proposed rule and went straight to ruling it out in the Final Rule. "Therapists can still deliver group therapy, but they can't count it toward the 3-hour rule," Fowler says.

Another important clarification was that IRFs may not use aides to satisfy the 3-hour rule, points out **Rick Gawenda, PT,** director of PM&R for Detroit ReceivingHospital. The Final Rule's exact words are: "Therapy aides are authorized to perform support services for licensed and/or certified skilled therapy practitioners ... therapy aide services are not considered skilled ..."

Note the Positives

If you're feeling overwhelmed by now, check out the bright side of the rule experts have noted. For example, while the payment updates in the Final Rule take effect Oct. 1, 2009, the coverage criteria changes will not take effect until Jan. 1, 2010. This is to "allow facilities time to change their operations as needed to comply with the final regulation," CMS explained.

Another bright spot: "The proposed rule said patients must show measurable improvements, meet the 3- hour rule, etc., but the Final Rule softened the language abit to a 'reasonable expectation' for the patient to participate in intensive rehab and show measurable improvements," Fowler says.

Finally, CMS said that it would allow some exceptions to the 3-hour rule if the patient can't tolerate that much therapy. "You can do 15 hours of therapy over seven days -- and that was a real positive," Fowler notes. You must, however, document why you delivered therapy this way, as opposed to the regular five-day requirement. Also, this means you'd need to staff your therapy seven days a week, which may not necessarily be good news for your facility.

Check Out Your Payment Updates

The Final Rule included a 2.5 percent update to the IRF payment rate and sets IRF outlier threshold at $10,652. Payment updates are effective Oct. 1, 2009. **Careful:** "I don't believe the 2.5 percent uptick is going to have a positive impact for rural and teaching hospitals," Fowler warns. "Their add-on payments were reduced -- teaching hospitals went from a 0.9 to a 0.68 multiplier, and rural hospitals went from a 21.3 to an 18.4." CMS did update the low-income patient and teaching status adjustment factors to reflect more recent data, but Fowler believes that it'll still be "a wash" or even a reduction for these facilities.