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Unclear Medicare Requirements Led to Differing Interpretations of Inpatient Rehabilitation Facility Documentation, Coverage, and Billing Requirements

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Why OIG Did This Audit

- A prior OIG nationwide review of inpatient rehabilitation facilities (IRFs) found that many IRF stays did not meet Medicare coverage and documentation requirements. The audit found that Medicare paid IRFs $5.7 billion (84 percent of the dollars covered by our audit) for care provided to enrollees that was not reasonable and necessary.
- After considering IRF stakeholders' concerns about the prior audit and, given the high dollar value of IRF claims and the previously identified error rate, OIG developed a one-time, collaborative approach with CMS and IRF stakeholders to determine the root causes of the varying interpretations of IRF regulations by OIG, IRF stakeholders, and CMS.

What OIG Found

- We determined that unclear Medicare requirements led to differing interpretations between OIG, IRF stakeholders, and CMS related to documentation, coverage, and billing requirements. Because these requirements are unclear, OIG, IRF stakeholders, and CMS had differing opinions on the allowability of the sampled claims, which raises concerns about increased risk of financial loss to the program, compromised program integrity, and operational inefficiency in the Medicare program.
- Our independent medical reviewer determined that 42 of 200 sampled IRF claims complied with Medicare requirements. However, the remaining 158 claims lacked documentation supporting that IRF care was in accordance with requirements.
- IRF stakeholders reviewed these 158 claims and reported an error rate in "the high teens to low twenties." They shared their rationale for 19 claims they determined to be in compliance with Medicare requirements. CMS reviewed those 19 claims and found that 14 met Medicare requirements and 5 did not.

What OIG Recommends

We made four recommendations to CMS, including that it revise or clarify IRF documentation, coverage, and billing requirements, and offer training and learning sessions to IRFs to assist in compliance with regulations. The full recommendations are in the report.

CMS did not concur with three of our recommendations and concurred with our remaining recommendation.

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INTRODUCTION

WHY WE DID THIS AUDIT

A prior Office of Inspector General (OIG) audit of inpatient rehabilitation facilities (IRFs) found that many IRF stays (the total number of days an enrollee is in an IRF) did not meet Medicare coverage and documentation requirements.[1] In that audit, OIG found that Medicare paid IRFs $5.7 billion (84 percent of the dollars covered by our audit) for care provided to enrollees that was not reasonable and necessary. The Centers for Medicare & Medicaid Services (CMS) concurred with our recommendations and described actions it would take to address them.[2]

In response to our prior audit, the American Medical Rehabilitation Providers Association, the American Academy of Physical Medicine and Rehabilitation, and the Federation of American Hospitals, hereafter referred to as the "IRF stakeholders," sent a letter to OIG questioning our methodology, strict interpretations of regulatory requirements, and what the IRF stakeholders perceived as second guessing the physicians involved in the care of IRF enrollees.

After considering the IRF stakeholders' concerns about our prior audit and, given the high dollar value of IRF claims and the previously identified error rate, we developed a one-time, collaborative approach—with CMS and IRF stakeholders—for this audit to determine the root causes of the varying interpretations of IRF regulations by OIG, IRF stakeholders, and CMS. In this audit, we make recommendations that would improve efficiency and accuracy of IRF claims and payments and strengthen program integrity.[3]

OBJECTIVE

Our objective was to identify areas in which CMS could clarify Medicare IRF claims payment requirements.

BACKGROUND

The Medicare Program and Inpatient Rehabilitation Facilities

The Medicare program provides health insurance coverage to people aged 65 and older, people with disabilities, and people with end-stage renal disease. CMS administers the Medicare

[1] OIG, *Many Inpatient Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements* (A-01-15-00500), Sept. 27, 2018.

[2] We made a series of recommendations to CMS, including that it educate IRF personnel on Medicare coverage and documentation requirements, work with providers to develop best practices to improve internal controls, and increase its oversight activities for IRFs.

[3] We did not design this audit to report an IRF claims error rate or to recommend recovery of improperly paid claims.

program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for enrollees after hospital discharge. CMS uses Medicare contractors to, among other things, process and pay claims submitted by hospitals, including IRFs. IRFs provide intensive inpatient rehabilitation therapy in acute-care units of inpatient hospitals or freestanding rehabilitation hospitals for enrollees whose complex medical, nursing, and therapy needs require—and who are expected to benefit from—an inpatient stay and an interdisciplinary team (IDT) approach to care.[4]

Inpatient Rehabilitation Facilities Prospective Payment System

CMS implemented the IRF prospective payment system (PPS) under section 1886(j) of the Social Security Act (the Act). Under the PPS, Medicare enrollees are assigned to case-mix groups based on the primary reason for intensive rehabilitation care (e.g., a stroke or hip fracture), age, and level of motor and cognitive function. Within each of these case-mix groups, enrollees are further categorized into one of four tiers based on the presence of specific comorbidities that have been found to increase the cost of care.[5]

Under the PPS, IRFs are reimbursed at a rate generally 2.5 times greater than the acute inpatient PPS rate because of the complexity of the care involved.[6] In exchange, Medicare requires IRFs to provide intensive rehabilitation to enrollees with more severe conditions.[7]

Inpatient Rehabilitation Facilities Coverage and Documentation Requirements

No Medicare payment may be made for items or services that are not reasonable and necessary for diagnosing or treating illness or injury or for improving the functioning of a malformed body member.[8] Current coverage requirements specify that, to be considered reasonable and necessary under section 1862(a)(1) of the Act, there must have been a reasonable expectation at the time of the enrollee's admission to the IRF that the enrollee:[9]

[4] CMS, *Medicare Benefit Policy Manual* (the Manual), Pub. No. 100-02, chapter 1, § 110.

[5] 42 CFR § 412.620; 86 Fed. Reg. 42362, 42369-42372, 42380-24381 (Aug. 4, 2021). Medicare Payment Advisory Commission (MedPAC), *Inpatient Rehabilitation Facilities Payment System*, Revised October 2020. Accessed on Sept. 30, 2025.

[6] We noted that the MedPAC (an independent, nonpartisan legislative branch agency) has recommended a payment rate reduction of 7 percent for fiscal year 2026.

[7] Barbara Gage et al., *Analysis of the Classification Criteria for Inpatient Rehabilitation Facilities (IRFs)*, Report to Congress, September 2009, p. 13. Accessed on Sept. 30, 2025.

[8] The Act, § 1862(a)(1)(A).

[9] 42 CFR § 412.622(a)(3).

- Required the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy [PT], occupational therapy [OT], speech-language pathology [ST], or prosthetics/orthotics therapy), one of which must be PT or OT

- Generally required and could have been reasonably expected to actively participate in, and benefit from, an intensive rehabilitation therapy program[10]

- Was sufficiently stable at the time of admission to the IRF to be able to actively participate in the intensive rehabilitation therapy program

- Required physician supervision by a rehabilitation physician[11, 12]

To be considered reasonable and necessary under section 1862(a)(1) of the Act, the enrollee must require an IDT approach to care, as evidenced by documentation in the enrollee's medical record of weekly IDT meetings that meet all requirements.[13] Current documentation requirements specify that the enrollee's medical record at the IRF must include the following documentation with all required elements: (1) a comprehensive preadmission screening completed within 48 hours preceding the admission and (2) an individualized overall plan of care (POC) developed within 4 days of admission.[14, 15]

[10] Under current industry standards, an intensive rehabilitation therapy program generally consists of at least 3 hours of therapy (PT, OT, ST, or prosthetics/orthotics therapy) per day at least 5 days per week. In certain well-documented cases, therapy might instead consist of at least 15 hours of intensive rehabilitation therapy per week. Benefit from this intensive rehabilitation therapy program is demonstrated by measurable improvement that will be of practical value to the enrollee in improving their functional capacity or adaptation to impairments (42 CFR § 412.622(a)(3)(ii)).

[11] Specifically, a rehabilitation physician must conduct face-to-face visits with the enrollee at least 3 days per week throughout the enrollee's IRF stay. These meetings are meant to assess the enrollee both medically and functionally and to modify the course of treatment as needed to maximize the enrollee's capacity to benefit from the rehabilitation process. During the COVID-19 public health emergency (PHE), such visits were permitted using telehealth services (42 CFR § 412.622(a)(3)(iv)). Our audit period (Oct. 1, 2021, through Sept. 30, 2022) was during the PHE.

[12] Coverage requirements detailed in the first, third, and fourth bullet points did not apply to enrollees in a freestanding IRF hospital solely to relieve acute-care hospital capacity in a State or region that was experiencing a surge during the COVID-19 PHE (42 CFR §§ 412.622(a)(3)(i, iii, and iv)). The coverage requirement in the second bullet point did not apply during the COVID-19 PHE (42 CFR § 412.622(a)(3)(ii); 85 Fed. Reg. 27550, 27572 (May 8, 2020)).

[13] 42 CFR § 412.622(a)(5). This requirement did not apply to enrollees in a freestanding IRF hospital solely to relieve acute-care hospital capacity in a State or region that was experiencing a surge during the COVID-19 PHE.

[14] 42 CFR § 412.622(a)(5). These requirements did not apply to enrollees in a freestanding IRF hospital solely to relieve acute-care hospital capacity in a State or region that was experiencing a surge during the COVID-19 PHE.

[15] CMS has not defined the term "individualized overall plan of care" in notice-and-comment rulemaking.

HOW WE CONDUCTED THIS AUDIT

Our audit covered $7 billion in Medicare payments to 1,109 IRFs for 300,269 IRF claims in Federal fiscal year (FFY) 2022 (audit period).[16] We selected for review a stratified random sample of 200 IRF claims with payments totaling $5,029,335 for stays at 177 IRFs.[17]

We submitted all 200 IRF claims and corresponding medical records to an independent medical review contractor to determine whether sampled IRF claims met Medicare documentation, coverage, and billing and coding requirements using a medical review questionnaire, known as the Medical Review Instrument (MRI) (See Appendix B). OIG developed the MRI and provided it to CMS and IRF stakeholders to ensure that all parties shared an understanding of the applicable requirements, acknowledged these questions would be used to test compliance with those criteria, and had an opportunity for feedback on the MRI. Our independent medical review contractor hired an experienced, board-certified Physical Medicine and Rehabilitation physician to review these claims.

We provided the IRF stakeholders with the independent medical review contractor's determination letters and corresponding medical records for sampled IRF claims that the medical review contractor found to be in error (i.e., noncompliant with Medicare requirements) so that the IRF stakeholders could review our findings, perform their own review, and share their results.[18]

From these sampled IRF claims, the IRF stakeholders selected 19 claims they said highlighted substantive issues with the results of our medical review. We then provided the corresponding 19 medical records and determination letters to CMS officials so they could review our findings, perform their own review, and share their results. We subsequently discussed these 19 claims with IRF stakeholders, CMS, and the independent medical review contractor during a 2-day, in-person meeting and through subsequent correspondence. The examples in the findings below include some of the substantive issues related to the 19 IRF claims discussed during our meeting and followup correspondence.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions

[16] Total Medicare claims paid was $7,046,305,401. FFY 2022 is Oct. 1, 2021, through Sept. 30, 2022. The data for this period were the most current data available when we started this audit.

[17] Our sample included 91 claims from 84 hospital-based IRFs and 109 claims from 93 freestanding IRFs. The number of IRFs does not total 200 because some IRFs had multiple sample items.

[18] We redacted all personally identifiable information from the medical records before providing them to the IRF stakeholders. Also, we secured nondisclosure agreements from IRF stakeholder participants to whom we sent, and who otherwise were given access to, the medical records to further ensure against the disclosure of personally identifiable information. The IRF stakeholder participants also agreed to not disclose any of the communications among them, OIG, and CMS, to protect the integrity of the audit and the free exchange of ideas.

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

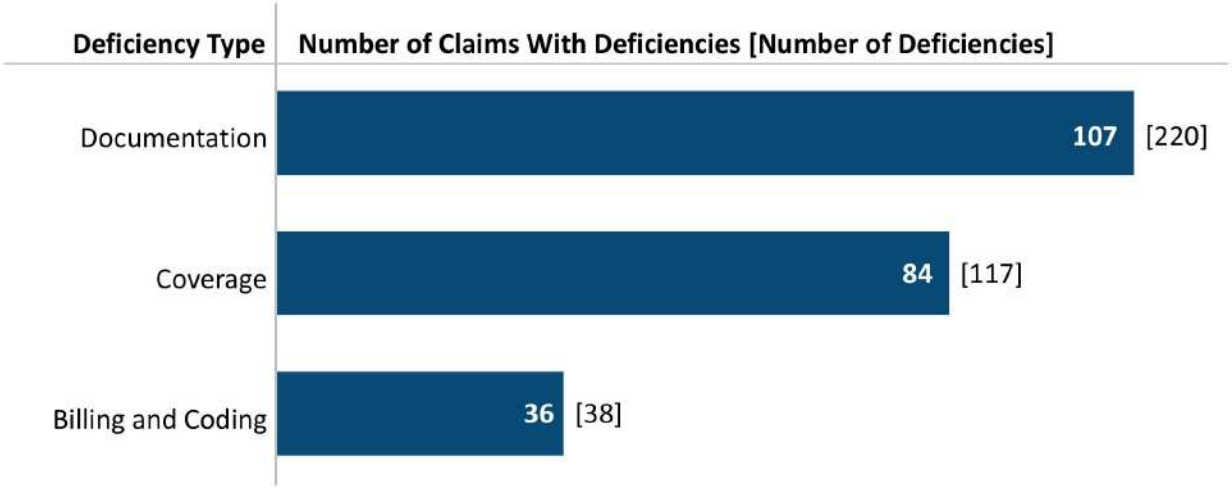
Appendix A contains the details of our audit scope and methodology, Appendix B contains our MRI, Appendix C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

FINDINGS

We determined that unclear Medicare requirements led to differing interpretations between OIG, IRF stakeholders, and CMS related to documentation, coverage, and billing requirements. Because these requirements are unclear, OIG, IRF stakeholders, and CMS had differing opinions on the allowability of the sampled claims, which raises concerns about increased risk of financial loss to the program, compromised program integrity, and operational inefficiency in the Medicare program.

Our independent medical review contractor determined that 42 of the 200 sampled IRF claims complied with Medicare IRF requirements; however, the remaining 158 claims lacked documentation supporting that IRF care was in accordance with requirements. These 158 IRF claims included 375 deficiencies (see Figure 1) with overpayments totaling $3,416,616.[19]

Figure 1: OIG Contractor-Determined Deficiencies



Note: The total number of claims with deficiencies and number of deficiencies exceed 158 because for 79 claims we identified multiple deficiencies related to multiple categories. For overpayment estimation purposes, we only counted each IRF claim one time.

IRF stakeholders reviewed all 158 IRF claims found to be deficient by our independent medical review contractor and reported an error rate in "the high teens to low twenties," but they did not provide OIG with the full results of their reviews. Instead, they shared their rationale for 19 claims they determined to be in compliance with Medicare requirements. CMS reviewed those

[19] The number of deficiencies (375) is greater than 158 because 112 IRF claims had multiple deficiencies.

19 claims and found that 14 met Medicare requirements and 5 did not.[20] The differences in interpretations of CMS's regulations we identified raise substantial concerns given the large payment amounts at risk.

On the basis of our sample results, we estimated that Medicare paid IRFs approximately $5 billion for IRF claims that our independent medical review contractor determined did not meet Medicare documentation, coverage, and billing and coding requirements. This amount represents 71 percent of the dollars in our sampling frame of IRF claims paid in FFY 2022 and indicates a significant risk to program integrity.

UNCLEAR MEDICARE REQUIREMENTS LED TO DIFFERING INTERPRETATIONS OF DOCUMENTATION, COVERAGE, AND BILLING REQUIREMENTS

As described above, our independent medical review contractor determined that 158 of 200 sampled IRF claims did not meet Medicare documentation, coverage, and billing and coding requirements. Based on the medical review contractor's determination and corresponding medical records, the IRF stakeholders selected 19 of these IRF claims that they felt highlighted substantive issues. The examples in the findings below illustrate how OIG, the IRF stakeholders, and CMS interpret the same regulations differently.

DOCUMENTATION REQUIREMENTS

Our independent medical review contractor determined that 107 sampled IRF claims did not comply with Medicare documentation requirements.[21] Specifically, IRFs billed Medicare for services that did not meet POC requirements (86 claims), did not meet weekly IDT meeting requirements (65 claims), did not meet preadmission screening requirements (12 claims), or did not meet therapy discipline requirements (4 claims).[22] As a result, we were unable to determine whether IRF care for these enrollees was reasonable and necessary.[23] Figure 2 on the next page provides a breakdown of the documentation deficiency types, number of IRF deficiencies, and total number of deficiencies.

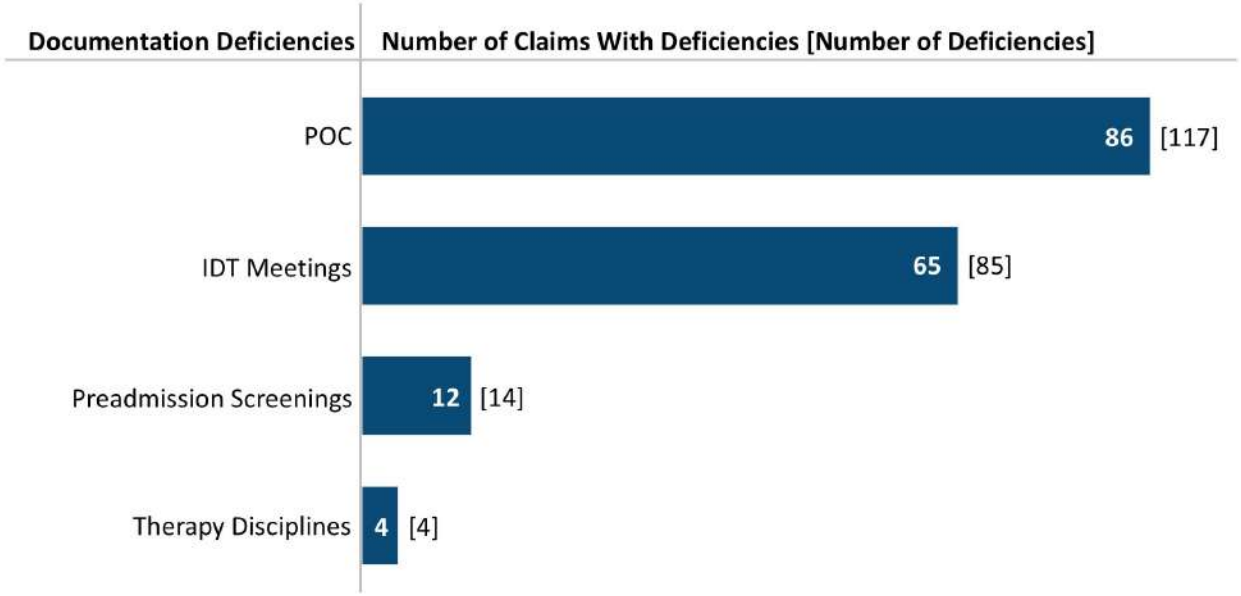
[20] Of the five claims that according to CMS did not meet Medicare requirements, two claims each contained a deficiency also identified by our independent medical review contractor, and three claims each contained a deficiency not found by our independent medical review contractor.

[21] There are 220 deficiencies associated with the 107 IRF claims because 77 IRF claims have more than 1 type of documentation deficiency.

[22] Each claim could have deficiencies in more than one of the error categories, which results in the total number of claims with deficiencies exceeding 107 IRF claims. We only counted each IRF claim once for overpayment estimation purposes.

[23] This documentation is expressly required in order to show that each enrollee for whom the IRF seeks payment is reasonably expected to meet all the IRF coverage requirements that must be met for an IRF claim to be considered reasonable and necessary (42 CFR § 412.622(a)(4)).

Figure 2: OIG Contractor-Determined Documentation Deficiencies



Note: Each claim could have deficiencies in more than one of the above categories, which results in the total number of IRF deficiencies exceeding 107 IRF claims. We only counted each IRF claim once for overpayment estimation purposes.

Plan of Care

An enrollee's medical record at the IRF must contain an individualized overall POC "developed by a rehabilitation physician with input from the [IDT] within 4 days of the enrollee's admission to the IRF."[24]

Our independent medical review contractor determined that 86 sampled IRF claims contained 117 deficiencies related to medical records that did not support POC documentation requirements.[25] Specifically:

- Seventy-one IRF claims had an associated POC that was not developed by a rehabilitation physician with input from the IDT (see Example 1 on the next page).

- Thirty-five IRF claims had an associated POC that did not demonstrate individualization (see Example 2 on the next page).

- Six IRF claims had an associated POC that was not developed within 4 days of the enrollee's admission to the IRF.

[24] 42 CFR §§ 412.622(a)(4)(ii)(A) and (B).

[25] The total number of deficiencies exceeds 86 because 21 IRF claims contained more than 1 POC deficiency.

- Five IRF claims did not have an associated POC in the associated medical record.[26]

Example 1: Plan of Care Not Developed by a Rehabilitation Physician

Entity	Did IRF Meet Requirement?	Rationale
OIG	**No**	Although documentation indicated that the rehabilitation physician approved (signed) the POC, there was no documentation to support that the IDT was involved in its development.
IRF Stakeholders	**Yes**	Documentation showed that the IDT contributed to the POC before the rehabilitation physician approved it. Specifically, the IDT input on the POC was individualized with assessments, goals, planned interventions, and levels of PT and OT.
CMS	**Yes**	To meet requirements, the medical record would include documentation of the overall POC and a dated signature from the rehabilitation physician, demonstrating approval of the overall POC.

Example 2: Plan of Care Not Individualized

Entity	Did IRF Meet Requirement?	Rationale
OIG	**No**	The medical prognosis contained generic/templated language and did not reflect or address the enrollee's specific medical needs. Specific assessments; planned interventions; and current level of function for PT, OT, and ST were not included in the POC.
IRF Stakeholders	**Yes**	The POC has multiple examples of individualization, including therapy duration and frequency, PT and OT outcome goals, estimated length of stay, and discharge location.
CMS	**Yes**	The medical record met statutory and regulatory requirements by documenting the need for intensive therapy (e.g., OT and PT), the enrollee's ability to participate, and physician oversight.

Although CMS requires that an enrollee's medical record at the IRF contain a POC developed by a rehabilitation physician and be individualized, CMS requirements do not explain what "developed by" or "individualized" means or what should be documented. Because the requirements associated with these terms are unclear, OIG, IRF stakeholders, and CMS had different opinions on the allowability of the sampled claims.

[26] In our discussions with CMS and IRF stakeholders, we did not discuss the deficiencies associated with a POC not being developed within 4 days of the enrollee's admission to the IRF or not being included in the enrollee's medical records. Therefore, we did not identify a difference of opinion on the allowability of these claims. Nevertheless, we believe the deficiencies are relevant to our audit objective to identify areas in which CMS should clarify IRF requirements and are therefore included in this report. We are reporting these deficiencies due to the increased risk that the enrollees' specific needs were not adequately addressed. In addition, there is an increased risk of financial loss to and inefficiency in the Medicare program.

Weekly Interdisciplinary Team Meetings

According to CMS regulations, there must be documentation that weekly IDT meetings were "led" by a rehabilitation physician and included all required participants (i.e., a rehabilitation physician, a registered nurse, a social worker or case manager, and a licensed or certified therapist from each therapy discipline involved in treating the enrollee). In addition, there must be documentation that the IDT met at least once per week throughout the enrollee's IRF stay to review the enrollee's progress toward stated rehabilitation goals and identify any problems that could impede progress toward those goals. Furthermore, the results and findings of weekly IDT meetings—and the concurrence by the rehabilitation physician with the results and findings—should be retained in the enrollee's medical record (42 CFR §§ 412.622(a)(5)(i-iii)).

Our independent medical review contractor determined that 65 sampled IRF claims contained 85 IDT deficiencies related to medical records that did not support weekly IDT meeting documentation requirements.[27] Specifically:

- Sixty-one IRF claims did not have documentation to support that a rehabilitation physician led each IDT meeting throughout the enrollee's IRF stay (see Example 3 on the next page).

- Eleven IRF claims did not have documentation to support that the rehabilitation physician concurred with the results and findings of each IDT meeting.

- Five IRF claims did not have documentation to support that all required participants attended each IDT meeting.

- Four IRF claims did not have documentation to support that the IDT reviewed the enrollee's progress toward goals or identified any problems that could impede progress at each IDT meeting (see Example 4 on page 11).

- Three IRF claims did not have documentation to support that IDT meetings occurred at least once per week throughout the enrollee's IRF stay.

[27] Thirteen IRF claims contained more than one IDT meeting deficiency.

- One IRF claim did not have documentation of the results and findings of each IDT meeting.[28]

Example 3: Weekly Interdisciplinary Team Meeting Not Led by Rehabilitation Physician

Entity	Did IRF Meet Requirement?	Rationale
OIG	**No**	Although documentation showed that the rehabilitation physician attended the IDT meeting and concurred with meeting findings, it did not support or establish that the rehabilitation physician led each IDT meeting. Our independent medical review contractor stated that if the records only contained proof that the rehabilitation physician was present at the IDT meeting and concurred with the findings, there was no way of knowing if the rehabilitation physician led the meeting.
IRF Stakeholders	**Yes**	The medical review contractor's reliance on the word "led" overlooked clear indications in the medical record that the rehabilitation physician led the IDT meetings. Physician participation should be presumed to satisfy the leadership requirement.
CMS	**Yes**	Documentation showing that the physician attended and participated in the IDT meetings (either in person or remotely) would meet the criteria.

[28] In our discussions with CMS and IRF stakeholders, we did not discuss the deficiencies associated with: (1) the rehabilitation physician concurring with the results of each IDT meeting, (2) documenting all required participants attending each IDT meeting, (3) documenting that IDT meetings occurred at least once per week throughout the enrollee's IRF stay, and (4) documenting that the results and findings of each IDT meeting were not discussed during our meeting. Therefore, we did not identify a difference of opinion on the allowability of these claims. Nevertheless, we believe these deficiencies are relevant to our audit objective to identify areas in which CMS should clarify IRF requirements and are therefore included in this report. We are reporting these deficiencies due to the increased risk that the enrollees' specific needs were not adequately addressed. In addition, there is an increased risk of financial loss to and inefficiency in the Medicare program.

Example 4: Interdisciplinary Team Did Not Review the Enrollee's Progress Toward Goals During Meetings

Entity	Did IRF Meet Requirement?	Rationale
OIG	**No**	Medical records did not support that the IDT reviewed the enrollee's progress toward stated rehabilitation goals at the IDT meeting. According to our independent medical review contractor, the records did not include confirmation that the enrollee's progress toward stated rehabilitation goals were documented by the therapist and reviewed during the IDT meeting (e.g., not prepopulated on a template).
IRF Stakeholders	**Yes**	Medical records contained OT, PT, and ST goals. In addition to IDT meetings, other records tracked week-to-week progress toward goals. The IRF stakeholders expressed concerns that OIG is holding providers to standards that are not in regulations.
CMS	**Yes**	Medical records included the necessary information to meet statutory and regulatory requirements (e.g., progress toward stated goals). However, the claim did not meet Medicare requirements for a different reason.[29]

CMS regulations state that there must be documentation that the IDT meeting is led by the rehabilitation physician and that the IDT review the enrollee's progress toward stated rehabilitation goals and identify any problems that could impede progress toward those goals at each IDT meeting. However, CMS requirements do not explain what "led" means or how to document the review of an enrollee's progress and identification of any problems that could impede progress toward those goals at each IDT meeting, including what needs to be documented. OIG, IRF stakeholders, and CMS had different interpretations of the IDT requirements and therefore on what is required for IDT meetings.

Preadmission Screenings

According to CMS regulations, the enrollee's medical record must include a comprehensive preadmission screening completed or updated within 48 hours immediately preceding the IRF admission.[30] This screening must document various elements, including the enrollee's prior functional status, expected level of improvement, expected length of time necessary to achieve

[29] Although CMS determined that the IRF met the requirement related to the IDT reviewing the enrollee's progress toward stated goals during the IDT meeting, it nevertheless determined that the claim did not meet Medicare requirements because the medical records did not show a clear rehabilitative need that would require the structured, multidisciplinary approach of an IRF. In addition, the clinical picture of the enrollee did not support the need for active and ongoing therapy from multiple disciplines at an intensity consistent with IRF standards.

[30] 42 CFR § 412.622(a)(4)(i)(A).

that level of improvement, anticipated discharge destination, and risk for clinical complications.[31]

Our independent medical review contractor determined that 12 sampled IRF claims contained 14 preadmission screening deficiencies related to medical records that did not support preadmission screening documentation requirements. Specifically:[32]

- Seven IRF claims did not have documentation of the enrollee's expected level of improvement.

- Two IRF claims did not have documentation of the enrollee's functional status prior to the event or condition that led to the enrollee's need for intensive rehabilitation therapy (see Example 5 on the next page).

- Two IRF claims did not have documentation of an evaluation of the enrollee's risk for clinical complications.

- One IRF claim did not have documentation of the expected timeframe needed to achieve improvement.

- One IRF claim did not have documentation of the anticipated discharge destination.

- One IRF claim did not have documentation to support that a preadmission screening was conducted or updated within 48 hours immediately preceding the admission (see Example 6 on the next page).[33]

[31] 42 CFR § 412.622(a)(4)(i)(B).

[32] Two IRF claims contained more than one preadmission screening deficiency.

[33] In our discussions with CMS and IRF stakeholders, we did not discuss the deficiencies associated with: (1) documenting the enrollee's expected level of improvement, (2) evaluating the enrollee's risk for clinical complications, (3) the expected timeframe needed to achieve improvement, and (4) the discussion of the enrollee's anticipated discharge destination. In addition, CMS agreed with our rationale for the deficiency related to documentation that the preadmission screening was not conducted or updated within 48 hours immediately preceding the admission. Therefore, we did not identify a difference of opinion on the allowability of these claims. Nevertheless, we believe these deficiencies are relevant to our audit objective to identify areas in which CMS should clarify IRF requirements and are therefore included in this report. We are reporting these deficiencies due to the increased risk that the enrollees' specific needs were not adequately addressed. In addition, there is an increased risk of financial loss to and inefficiency in the Medicare program.

Example 5: Inadequate Documentation of an Enrollee's Functional Status Prior to Intensive Rehabilitation Therapy

Entity	Did IRF Meet Requirement?	Rationale
OIG	**No**	Documentation did not support the enrollee's functional status prior to the condition that led to the need for intensive rehabilitation therapy. Our medical review contractor mentioned that the medical records were vague, causing a difference of opinion, and recommended the medical record needed clear language to reduce the chances for misinterpretation.
IRF Stakeholders	**Yes**	The medical record documented the enrollee's prior functional status, which is relevant because it represented the status the enrollee aimed to return to after the IRF stay.
CMS	**Yes**	Documentation supported that therapy services were reasonable and necessary at the intensity required for an IRF stay. It described the enrollee's level of function before the event or condition that led to the need for intensive rehabilitation therapy, focusing on functions that declined because of that event or condition. The documentation also supported the enrollee's need for intensive rehab, ability to participate, and expected therapies.

Example 6: Inadequate Documentation That a Preadmission Screening Was Conducted or Updated Within 48 Hours Immediately Preceding the Admission

Entity	Did IRF Meet Requirement?	Rationale
OIG	**No**	Documentation did not support that the preadmission screening was conducted or updated within 48 hours immediately preceding the admission.
IRF Stakeholders	**Yes**	The preadmission screening was updated within 48 hours of admission to show the enrollee's current functional status. Specifically, the screening was updated to show the enrollee underwent a procedure in an acute-care hospital just prior to IRF admission. Additionally, the preadmission screening was updated on the day of the IRF admission for a COVID test in an acute-care hospital.
CMS	**No**	The physician should have included additional information to show there was no change or update to the enrollee's medical and functional status.

CMS regulations state that the preadmission screening must document the enrollee's functional status before the condition requiring intensive rehabilitation and be completed or updated within 48 hours immediately preceding the admission. However, CMS does not specify what should be documented in terms of prior functional status and what needs to be updated within 48 hours immediately preceding the admission when a preadmission screening was performed.

Because the requirements on what should be documented and updated are unclear, OIG, IRF stakeholders, and CMS had different opinions on the allowability of the sampled claims.

Therapy Disciplines

Enrollees admitted to IRFs receive active and ongoing therapeutic intervention of multiple therapy disciplines (PT, OT, ST, or prosthetics/orthotics therapy).[34] The Act and regulations require IRFs to provide sufficient information necessary to determine whether payment for services is due and the amount of the payment.[35]

Our independent medical review contractor determined that four sampled IRF claims contained four deficiencies related to medical records that did not include the required documentation to demonstrate that the enrollee received rehabilitation therapy services. Specifically:

- Two IRF claims did not have documentation of the PT, OT, or ST evaluation or progress notes documenting that rehabilitation therapy services were delivered.

- Two IRF claims did not have documentation to support that the enrollee received rehabilitation therapy services because the enrollee was either transferred to an acute-care hospital for other services or refused therapy services.

CMS and IRF stakeholders did not express any disagreement with these deficiencies; therefore, we did not identify a difference of opinion on the allowability of these claims. Failure to document that the rehabilitation therapy services were provided may lead to an increased risk that an enrollee's specific needs were not adequately addressed. In addition, there is an increased risk of financial loss to and inefficiency in the Medicare program.

COVERAGE REQUIREMENTS

Our independent medical review contractor determined that medical record documentation for 84 IRF claims did not comply with Medicare coverage requirements.[36] Specifically, IRFs incorrectly billed Medicare for services that did not meet coverage requirements related to: physician supervision at time of IRF admission (68 claims), active and ongoing therapeutic intervention of multiple therapy disciplines (42 claims), the enrollee being sufficiently stable to actively participate in a rehabilitation therapy program (6 claims), or face-to-face visits (1 claim). As a result, we were unable to determine whether IRF care for these enrollees was

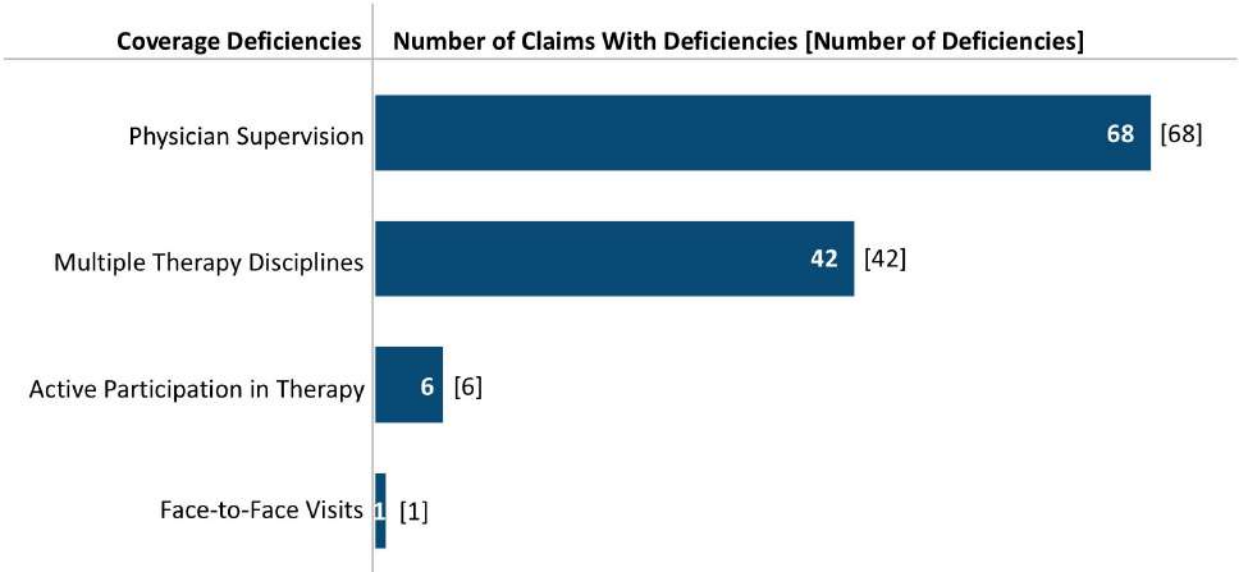
[34] 42 CFR § 412.622(a)(3)(i).

[35] The Act § 1815(a); 42 CFR § 424.5(a)(6).

[36] We identified 117 deficiencies associated with the 84 IRF claims because 33 IRF claims had more than 1 type of coverage deficiency.

reasonable and necessary.[37] Figure 3 below provides a breakdown of the coverage deficiency types, number of IRF deficiencies, and total number of deficiencies.

Figure 3: OIG Contractor-Determined Coverage Deficiencies



Note: Each claim could have deficiencies in more than one of the above categories, which results in the total number of IRF deficiencies exceeding 84 IRF claims. We only counted each IRF claim once for overpayment estimation purposes.

Need for Rehabilitation Physician Supervision at Time of Inpatient Rehabilitation Facility Admission

Medicare coverage requires that, upon admission to the IRF, there is a reasonable expectation that the enrollee requires supervision by a rehabilitation physician.[38]

Our independent medical review contractor determined that 68 sampled IRF claims contained 68 deficiencies related to medical records that did not support that there was a reasonable expectation at the time of IRF admission that the enrollee required supervision by a rehabilitation physician (see Example 7 on the next page).

[37] To be considered reasonable and necessary under section 1862(a)(1) of the Act, there must be a reasonable expectation that the enrollee meets all of these requirements at the time of the enrollee's admission to the IRF (42 CFR § 412.622(a)(3)).

[38] 42 CFR § 412.622(a)(3)(iv).

Example 7: Inadequate Documentation the Enrollee Required Supervision by a Rehabilitation Physician at the Time of Inpatient Rehabilitation Facility Admission

Entity	Did IRF Meet Requirement?	Rationale
OIG	**No**	Documentation did not support a reasonable expectation that at the time of IRF admission the enrollee required supervision by a rehabilitation physician. The enrollee had been medically stabilized at an acute-care hospital and was at or near their functional baseline. Also, they had recently undergone an acute inpatient rehabilitation course and had no ongoing significant or complex rehabilitation needs.
IRF Stakeholders	**Yes**	The preadmission screening documented the need for PT and OT, supported by recent evaluations recommending continued therapy. The rehabilitation physician's signature confirmed the need for an intensive, coordinated interdisciplinary approach. A rehabilitation physician has expertise in caring for enrollees with these needs.
CMS	**Yes**	Documentation supported the need for supervision by the rehabilitation physician upon IRF admission.

Although CMS regulations state that there must be a reasonable expectation that at the time of admission to the IRF an enrollee requires supervision by a rehabilitation physician, CMS has not defined what this reasonable expectation for supervision means or specified how to document it. Because CMS has not defined how to document a reasonable expectation that an enrollee requires supervision by a rehabilitation physician, OIG, IRF stakeholders, and CMS had different opinions on the allowability of the sampled claims.

Multiple Therapy Disciplines

Medicare coverage requirements specify that at the time of IRF admission there must be a reasonable expectation that the enrollee requires active and ongoing therapeutic intervention from multiple therapy disciplines—PT, OT, ST, or prosthetics/orthotics therapy—one of which must be PT or OT.[39]

Our independent medical review contractor determined that 42 sampled IRF claims contained 42 deficiencies related to medical records that did not support that at the time of IRF admission there was a reasonable expectation that the enrollee required active and ongoing therapeutic intervention from multiple therapy disciplines (see Example 8 on the next page).

[39] 42 CFR § 412.622(a)(3)(i).

Example 8: Inadequate Documentation the Enrollee Required Active and Ongoing Therapy From Multiple Disciplines at Time of Admission

Entity	Did IRF Meet Requirement?	Rationale
OIG	**No**	Documentation did not support that there was a reasonable expectation that the enrollee required active, ongoing therapy from multiple disciplines at admission to the IRF. The enrollee had functional deficits noted in PT and OT evaluations, but they would have expected to return to their functional baseline with ongoing medical treatment. There were no complex or skilled therapy needs requiring active and ongoing multidisciplinary therapy services.
IRF Stakeholders	**Yes**	Documentation shows the enrollee had multiple chronic conditions and was at a high risk for falls, injuries, and adverse events without IRF care. During a hospital stay, a social worker, in collaboration with Adult Protective Services, concluded that the enrollee needed IRF-level care due to safety concerns. The enrollee returned home from IRF care improved and safety concerns were lessened.[40]
CMS	**Yes**	Documentation requirements for active and ongoing therapeutic intervention with multiple disciplines were met. However, the claim did not meet Medicare requirements for a different reason. Specifically, documentation did not support that there was a reasonable expectation that the enrollee required active, ongoing therapy from multiple disciplines.[41]

Although CMS regulations require a reasonable expectation at the time of admission that an enrollee requires active and ongoing therapeutic intervention of multiple therapy disciplines, CMS has not specified how to document this expectation. OIG, IRF stakeholders, and CMS had different opinions on the allowability of the sampled claims.

[40] IRF stakeholders did not directly address the issue of therapy interventions with multiple disciplines.

[41] CMS determined that the claim did not meet Medicare requirements because the preadmission screening had not been completed or updated in a timely manner.

Active Participation in a Therapy Program

Medicare coverage requirements specify that at the time of admission to an IRF there must be a reasonable expectation that the enrollee is sufficiently stable to be able to actively participate in an intensive rehabilitation therapy program.[42, 43]

Our independent medical review contractor determined that six sampled IRF claims contained six deficiencies related to medical records that did not support this expectation (see Example 9 below).

Example 9: Inadequate Documentation the Enrollee Was Sufficiently Stable To Actively Participate in Therapy at Time of Admission

Entity	Did IRF Meet Requirement?	Rationale
OIG	**No**	Documentation showed that the enrollee was not stable enough to actively participate in therapy at the time of their admission to the IRF. (Our independent medical review contractor looked at whether the enrollee could tolerate therapy treatment at the time of admission.)
IRF Stakeholders	**Yes**	The preadmission screening did not indicate that the enrollee could not tolerate therapy, and the records noted that IRF care was appropriate for the enrollee and that there was a good prognosis for progress. Although PT was initially limited due to hypotension and dizziness, the enrollee progressed during the IRF stay. IRF stakeholders presented that the medical record, in its entirety, showed that the enrollee was sufficiently stable and could actively participate in therapy treatments even though the IRF may have needed to monitor symptoms.
CMS	**Yes**	The claim met medical necessity requirements. The medical record showed the enrollee was sufficiently stable to actively participate in therapy. However, the claim did not meet Medicare requirements for a different reason.[44]

[42] 42 CFR § 412.622(a)(3)(iii).

[43] It is important to note that our audit period was during the COVID-19 PHE. Before and after the PHE, the requirement is that at the time of admission to an IRF there must be a reasonable expectation that the enrollee is sufficiently stable to be able to actively participate in an *intensive* rehabilitation therapy program (42 CFR § 412.622(a)(3)(iii)). For our audit, we asked whether the enrollee was sufficiently stable to be able to actively participate in a rehabilitation therapy program—not an *intensive* rehabilitation therapy program.

[44] Although CMS determined that the IRF met the requirement related to active participation in therapy, it determined that the sample claim did not meet Medicare requirements because the preadmission screening was missing sufficient information to determine that an evaluation of the enrollee's risk for clinical complications was performed before admission to the IRF.

Although CMS regulations require a reasonable expectation at the time of admission that an enrollee is sufficiently stable to be able to actively participate in an intensive rehabilitation therapy program, CMS has not defined the term "sufficiently stable" or specified how to document this expectation. OIG, IRF stakeholders, and CMS had different opinions on the allowability of the sampled claims.

Face-to-Face Visits

Medicare coverage requires that the rehabilitation physician must conduct face-to-face visits with the enrollee at least 3 days per week throughout the IRF stay to assess the enrollee both medically and functionally. Beginning with the second week of admission to the IRF, a nonphysician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may conduct one of the three required face-to-face visits with the enrollee per week, provided that such duties are within the nonphysician practitioner's scope of practice under applicable State law.[45]

Our independent medical review contractor determined that one sampled IRF claim contained one deficiency related to the medical record that did not document that the rehabilitation physician conducted face-to-face visits with the enrollee at least 3 days per week throughout the IRF stay.

CMS and IRF stakeholders did not express any disagreement with this deficiency; therefore, we did not identify a difference of opinion on the allowability of the sample claim.

BILLING AND CODING REQUIREMENTS

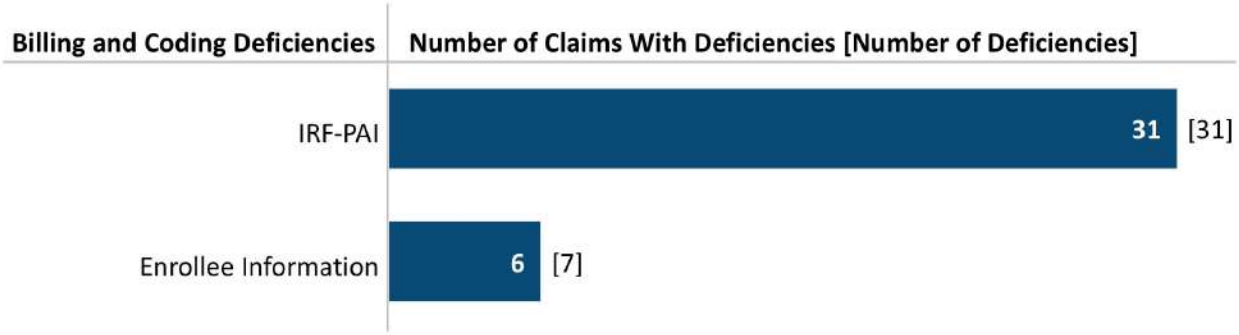
Our independent medical review contractor determined that medical record documentation for 36 sampled IRF claims did not comply with Medicare billing and coding requirements.[46] Specifically, IRFs incorrectly billed Medicare for claims that did not comply with billing and coding requirements related to the IRF Payment Assessment Instrument (IRF-PAI) (31 claims)[47] and were missing clinical information (6 claims). As a result, we were unable to determine whether these IRF claims should have been billed and reimbursed by Medicare. Figure 4 on the next page provides a breakdown of the billing and coding deficiency types, number of IRF deficiencies, and total number of deficiencies.

[45] 42 CFR § 412.622(a)(3)(iv).

[46] We identified 38 deficiencies associated with the 36 IRF claims because 2 IRF claims have more than 1 type of billing or coding deficiency.

[47] The IRF-PAI is used to determine payment and calculate quality measures for the IRF Quality Reporting Program and other quality indicators, providing a standardized way to assess the effectiveness of rehabilitation services.

Figure 4: OIG Contractor-Determined Billing and Coding Deficiencies



Note: Each claim could have deficiencies in more than one of the above categories, which results in the total number of IRF deficiencies exceeding 36 IRF claims. No overpayments were associated with the billing and coding deficiencies because the billing and coding requirements are not a condition of payment.

Inpatient Rehabilitation Facility Payment Assessment Instrument Discharge Assessment

Medicare requires IRF-PAI discharge assessments to be completed by the fifth calendar day after the enrollee is discharged from an IRF.[48, 49]

Our independent medical review contractor determined that 31 sampled IRF claims contained 31 deficiencies related to the discharge assessment not being completed by the fifth calendar day after the enrollee was discharged (see Example 10 on the next page).[50] Our independent medical review contractor used the date of the last signature on the IRF-PAI to determine whether the IRF-PAI was completed by the fifth calendar day.

[48] 42 CFR § 412.610(c)(2).

[49] The discharge assessment reference date is typically the day of discharge from the IRF and ensures standardization in how enrollee data is collected and reported. It also affects quality reporting, payment determination, and compliance with CMS regulations. This date is critical for ensuring that the data reflect the enrollee's status at discharge and for meeting submission deadlines.

[50] Of these 31 deficiencies, 11 were strictly because of an IRF-PAI timing issue. The IRF-PAI requirements are not a condition of payment; therefore, we counted these claims as deficiencies, but the claim amount paid is allowable.

Example 10: Inadequate Documentation Supporting the Discharge Assessment Was Completed by the Fifth Calendar Day Following Enrollee Discharge

Entity	Did IRF Meet Requirement?	Rationale
OIG	**No**	To determine the number of days between the enrollee's discharge and discharge assessment completion date, our independent medical review contractor used the dates of signatures on the IRF-PAI discharge assessment. The assessment was not completed by the fifth calendar day following the enrollee's discharge.
IRF Stakeholders	**Yes**	IRF stakeholders use the day the medical record is completed as the discharge assessment date. Therefore, the IRF-PAI discharge assessment was signed 1 day after the enrollee was discharged; however, because the IRF-PAI is not tracked, it is impossible to know what fields were completed or when.
CMS	**Yes**	The claim met Medicare requirements. All CMS policy and requirements were met.

CMS and IRF stakeholders stated that the Medicare requirement was met if the first signature on the IRF-PAI discharge assessment appears to have been present before the fifth calendar day, even if other signatures were added later. Our independent medical review contractor did not interpret the regulations to state that any signature would meet this requirement. Rather, the medical review contractor determined that the final signature indicates when the IRF-PAI discharge assessment is completed. CMS, however, has not defined whether the *first* or *final* signature on the IRF-PAI discharge assessment would satisfy the requirement. OIG, IRF stakeholders, and CMS had different opinions on which signature indicates completion of the IRF-PAI discharge assessment. These differing opinions may impact the timeliness of payment to IRFs and quality measures used by CMS.

Medical Record Clinical Information

Medicare documentation requirements specify that the enrollee's medical record must support the enrollee's primary condition or diagnosis, functional motor and cognitive abilities, and any comorbid conditions reported on the claim.[51]

Our independent medical review contractor determined that six IRF claims contained seven deficiencies related to medical records that did not support either the enrollee's primary condition or diagnosis (four claims), their motor and cognitive skills (two claims), or their comorbid conditions (one claim).[52]

[51] 42 CFR § 412.620(a).

[52] One IRF claim did not document the enrollee's primary condition or diagnosis or their comorbid conditions.

CMS and IRF stakeholders did not express any disagreement with these deficiencies; therefore, we did not identify a difference of opinion on the allowability of these claims. However, if the enrollee's medical record does not include the required documentation of their primary diagnosis, functional status, and comorbid conditions, the IRF claim may not meet Medicare's medical necessity requirements. This increases the risk of potentially improper payments and financial loss to and inefficiency in the Medicare program.

CONCLUSION

We determined that unclear Medicare requirements led to differing interpretations between OIG, IRF stakeholders, and CMS related to documentation, coverage, and billing requirements. Because these requirements are unclear, OIG, IRF stakeholders, and CMS had differing opinions on the allowability of the sampled claims, which raises concerns about increased risk of financial loss to the program, compromised program integrity, and operational inefficiency in the Medicare program.

On the basis of our sample results, we estimated that Medicare paid IRFs roughly $5 billion during the audit period for IRF claims that did not meet Medicare documentation, coverage, or billing and coding requirements. These deficiencies were due in part to unclear Medicare requirements, which led to differing interpretations of certain rules. Although IRF stakeholders expressed a desire to comply with the requirements, our audit found that the unclear requirements make it difficult to achieve consistent compliance, creating inefficiencies, and compromising program integrity. CMS should address the underlying causes of these issues to increase compliance and strengthen program integrity.

While it is CMS's responsibility to issue regulations that are free of ambiguity, the burden of compliance rests squarely with IRFs. It is the responsibility of taxpayer-funded IRFs that serve Medicare enrollees to maintain effective internal controls with respect to claims, provide training for their staff, seek guidance from CMS on accurate claims filing as needed, provide appropriate feedback to CMS on any proposed regulations, and take all other necessary steps to ensure compliance with CMS requirements.

RECOMMENDATIONS

- We recommend that CMS revise or clarify IRF documentation requirements related to the: (1) development and individualization of the POC, (2) leadership of IDT meetings by rehabilitation physicians, (3) review at IDT meetings of enrollee progress toward rehabilitation goals and identification of any problems that could impede such progress, and (4) functional status of enrollees during the preadmission screening.

- We recommend that CMS revise or clarify IRF coverage requirements to define: (1) what constitutes a reasonable expectation that an enrollee requires supervision by a rehabilitation physician, (2) what it means to have active and ongoing therapeutic intervention from multiple disciplines, and (3) what it means to be sufficiently stable to actively participate in an intensive rehabilitation therapy program.

- We recommend that CMS revise or clarify IRF-PAI signature requirements.

- We recommend that CMS offer training and learning sessions to assist IRFs with regulation compliance.

CMS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS did not concur with our first three recommendations to revise or clarify IRF documentation, coverage, and signature requirements. However, CMS concurred with our fourth recommendation to offer training and learning sessions to assist with compliance. CMS also indicated that, although it believes our findings and perceived risks may be overstated, it is committed to promoting compliance with Medicare requirements and reducing improper payments for IRF services.[53] Finally, CMS described its program integrity strategy to reduce and prevent Medicare improper payments and its actions to educate health care providers on the proper billing for IRF services. CMS also provided technical comments, which we addressed as appropriate.

After reviewing CMS's written comments, we acknowledge the program integrity activities CMS has undertaken to promote compliance and reduce improper payments for IRF services and commend CMS for its implementation of multiple initiatives to educate health care providers on Medicare requirements. We maintain that our findings and recommendations are valid.

CMS's comments, excluding technical comments, are included in their entirety as Appendix E.

RECOMMENDATIONS THAT CMS REVISE OR CLARIFY INPATIENT REHABILITATION FACILITY DOCUMENTATION, COVERAGE, AND SIGNATURE REQUIREMENTS

CMS Comments

CMS did not concur with our three recommendations to revise or clarify IRF documentation, coverage, and IRF-PAI signature requirements. CMS stated that it generally found that the sampled IRF claims discussed met Medicare requirements. Therefore, revisions or

[53] CMS noted that its most recent Comprehensive Error Rate Testing program reported an improper payment rate of 21.5 percent for IRFs with a projected improper payment amount of $1.6 billion.

clarifications of IRF documentation, coverage, and IRF-PAI signature requirements are not warranted based on our findings. CMS also indicated that the issues raised in this report related to these recommendations would be best addressed through education. CMS stated that it will continue to educate health care providers on Medicare requirements, including IRF documentation, coverage, and IRF-PAI signature requirements, to assist with compliance.

Office of Inspector General Response

We maintain that our recommendations that CMS revise or clarify IRF documentation, coverage, and IRF-PAI signature requirements are valid. Our independent medical review contractor identified numerous deficiencies related to these requirements, indicating that they were not isolated. Although CMS reviewed 19 claims, we want to reiterate that OIG's independent medical review contractor reviewed 200 claims and identified a 71 percent error rate. In addition, CMS has identified a Comprehensive Error Rate Testing improper payment rate of 21.5 percent related to IRF requirements. Furthermore, OIG continues to find IRF-related errors during individual provider audits at hospitals.[54] CMS should consider revising or clarifying documentation, coverage, and IRF-PAI signature requirements to improve compliance and strengthen program integrity. Our independent medical review contractor applied Medicare criteria as written. In the absence of CMS action on our recommendations, it is reasonable to expect that CMS and OIG will continue to find noncompliance with IRF requirements.

INPATIENT REHABILITATION FACILITIES STAKEHOLDERS' COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments, the IRF stakeholders partially agreed with our findings related to unclear Medicare requirements, generally agreed with our recommendations for CMS to clarify Medicare requirements and provide additional training, and provided additional recommendations for CMS to consider. Regarding our first and second recommendations, the IRF stakeholders asserted that there are some areas where greater clarity in CMS regulations would be helpful, but they do not believe more regulation is an effective solution. In addition, the IRF stakeholders indicated that Government auditors should give appropriate deference to rehabilitation physicians making clinical decisions at the time of IRF admission and throughout the course of IRF treatment. Furthermore, they stated that if any regulatory changes are made, they should be grounded in greater deference to the rehabilitation physician's role in decision making, reduce the burden on IRF providers, and simplify requirements to remove ambiguity.

The IRF stakeholders stated that the vast majority of IRF compliance issues we identified reflect good-faith differences in interpretation of medical necessity and documentation requirements, rather than clear noncompliance or fraud. The IRF stakeholders stated that most deficiencies stemmed from unclear Medicare regulations but cautioned against adding new ones. They also

[54] OIG, *Sarasota Memorial Hospital Received at Least $12.1 Million in Medicare Overpayments* (A-04-23-08098), Feb. 25, 2026.

cited our medical review contractors' restrictive interpretations as contributing to the high error rate. The stakeholders disagreed with our extrapolating the error rate to a dollar estimate. They also disagreed with our denying payment for an entire IRF stay based on a single technical documentation error unrelated to medical necessity.

After reviewing the IRF stakeholders' comments, we maintain that our findings, recommendations, and estimated overpayment are valid. We appreciate the stakeholders' engagement and their insights regarding potential factors contributing to the high error rates we identified. We note that this audit did not focus on identifying fraud, and we did not determine that any of the claims reviewed were fraudulently billed. To qualify for payment, the full duration of an IRF stay must meet all applicable documentation and coverage requirements. We used a statistically valid random sample to select our sample items for review and extrapolated the overpayment amount to provide context and show the effect these errors have on IRF providers. We worked with our independent medical review contractor to ensure that its review was conducted by a licensed rehabilitation physician, and that the appropriate Medicare criteria, as written, were applied.

Although the IRF stakeholders indicated that greater deference should be provided to rehabilitation physicians making clinical decisions, we believe that what is needed is additional clarification of documentation, coverage, and signature requirements. This will ensure that CMS, IRFs, rehabilitation physicians, Medicare contractors, and Government oversight agencies have the same understanding of what is required.

The IRF stakeholders' comments are included in their entirety as Appendix F.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $7 billion in Medicare payments to 1,109 IRFs for 300,269 IRF claims in FFY 2022. We selected for review a stratified random sample of 200 IRF claims with payments totaling $5,029,335 for stays at 177 IRFs. These 200 sample items consisted of 109 inpatient rehabilitation hospitals and 91 rehabilitation units of an acute-care hospital. We submitted all 200 IRF claims and corresponding medical records to an independent medical review contractor to determine whether sampled IRF claims met Medicare documentation, coverage, and billing and coding requirements using the MRI (Appendix B).

During our audit, we did not assess the overall internal control structure of CMS or the individual IRFs. Rather, we limited our review to CMS's internal controls for compliance with Medicare documentation, coverage, and billing and coding requirements. To evaluate these internal controls, we:

- Interviewed CMS officials regarding CMS's internal controls for compliance with Medicare documentation, coverage, and billing and coding requirements that related to IRF claims

- Reviewed CMS's policies and procedures for IRF documentation, coverage, and billing and coding requirements

- Reviewed a stratified random sample of 200 IRF claims to determine if IRF claims were properly billed and reimbursed

- Discussed the cause of the identified deficiencies with CMS officials

We performed audit work from November 2022 through January 2026.

METHODOLOGY

We took the following steps to accomplish our objective:

- Reviewed applicable Federal laws, regulations, and guidance

- Identified FFY 2022 Medicare-paid IRF claims using CMS's Integrated Data Repository

- Created a sampling frame of 300,269 FFY 2022 Medicare-paid IRF claims with a total paid amount of $7,046,305,401

- Selected a stratified random sample of 200 IRF claims from IRFs around the Nation with payments totaling $5,029,335

- Obtained medical records from IRFs for all sample items

- Contacted IRF providers for documentation requests and followup, as necessary

- Provided medical records for each sampled claim to an independent medical review contractor to determine whether the sampled claims met Medicare documentation, coverage, and billing and coding requirements, including rationale for claims upheld and denied

- Met with IRF stakeholders and CMS personnel on a collaborative approach for this audit, including discussing our sampling methodology, establishing timeframes for review, obtaining background information on personnel performing medical reviews, and identifying agreed-upon criteria (i.e., establish the MRI used by all parties)

- Collaborated with CMS and IRF stakeholders to review IRF claims that the independent medical review contractor determined included deficiencies

- Provided the medical records and our independent medical review contractor's determinations for 158 sampled IRF claim deficiencies to IRF stakeholders for their review and to obtain their medical review results

- Provided the medical records and our independent medical review contractor's determinations for 19 sampled IRF claim deficiencies identified by the IRF stakeholders to CMS officials for their review and to obtain their medical review results

- Analyzed and discussed the medical review results for 19 sampled IRF claims with our independent medical review contractor, IRF stakeholders, and CMS to identify:

    - Areas of agreement and disagreement on claims determinations

    - Causes of disagreements

- Used the results of the sample review to calculate the estimated Medicare overpayment for IRF claims in the sampling frame (Appendix D)

- Discussed the results of our audit with IRF stakeholders and CMS officials

APPENDIX B: MEDICAL REVIEW INSTRUMENT

Medical Review Instrument
Inpatient Rehabilitation Facility (IRF)- Nationwide
Review Period: FY 2022

References:

1. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1815(a)- Payment to Providers of Services
2. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1862(a)(1)(A)- Exclusions from Coverage and Medicare as a Secondary Payer
3. Social Security Act (SSA), Title XVIII- Health Insurance for the Aged and Disabled, Section 1886(j)- Prospective Payment for Inpatient Rehabilitation Services
4. 42 CFR §411.15(k)(1)- Any Services that are not Reasonable and Necessary
5. 42 CFR §412.602- Definitions
6. 42 CFR §412.604(c)- Completion of patient assessment instrument
7. 42 CFR §412.606(b)- Comprehensive Assessments
8. 42 CFR §412.610- Assessment Schedule
9. 42 CFR §412.618- Assessment process for interrupted stays
10. 42 CFR §412.620- Patient classification system
11. 42 CFR §412.622- Basis of Payment, (a)- Method of Payment, (3)- IRF Coverage Criteria, (4)- Documentation, and (5)- Interdisciplinary Team Approach to Care
12. 42 CFR §424.5(a)(6)- Sufficient Information
13. 42 CFR §424.32- Basic requirements for all claims
14. 45 CFR §162.1002(c)- Medical data code sets, for the period on or after October 1, 2015
15. Medicare Claims Processing Manual, Ch. 1- General Billing Requirements, §80.3.2.2 (Rev. 3086; 10-03-14)- Consistency Edits for Institutional Claims – "In order to be processed correctly and promptly, a bill must be completed accurately."
16. Medicare Claims Processing Manual, Chapter 3- Inpatient Hospital Billing, §140.3- Billing Requirements Under IRF PPS (Rev. 3030, Issued: 08-22-14, Effective: ASC X12: January 1, 2012, ICD-10: Upon Implementation of ICD -10, Implementation: ICD -10: Upon Implementation of ICD -10, ASC X12: September 23, 2014)

Review Rationale:

The purpose of this review is to determine whether IRF claims were compliant with Medicare requirements and beneficiaries met Medicare coverage requirements. The review also will determine whether IRF claims complied with Medicare coding requirements.

Note: Error codes are mapped to CMS Inpatient Rehabilitation Facilities Reason Codes and Statements or Generic Part A Reason Codes and Statements.

1

Note: This review will examine Medicare IRF claims paid in Federal fiscal year 2022 (October 1, 2021 - September 30, 2022). The Centers for Medicare & Medicaid Services (CMS) published amendments to 42 CFR §§ 602, 604, 606, 610, and 618, on August 1, 2022. These changes did not go into effect until October 1, 2022; therefore, the changes did not apply to the claims under review. The current (up-to-date) web version of the CFR (eCFR) – since it is now after October 1, 2022 – contains these changes. Please use the official version (paper or .pdf) of the CFR published on October 1, 2021, for this review.

Note: This review includes claims submitted by freestanding rehabilitation hospitals and rehabilitation units of hospitals. One IRF coverage requirement did not apply during the COVID-19 Public Health Emergency (42 CFR § 412.622(a)(3)(ii)). Four IRF coverage requirements, an IRF documentation requirement, and an IRF medical necessary requirement did not apply to patients in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE (42 CFR §§ 412.622(a)(3)(i), (a)(3)(iii), and (a)(3)(iv), (a)(4), and (a)(5)).

- The COVID-19 Public Health Emergency encompassed all of FY 2022.
- The OIG will identify whether each claim was submitted by a freestanding rehabilitation hospital or a rehabilitation unit of a hospital. The OIG will obtain this information from the provider's NPI on the claim.
- The OIG will identify whether each claim submitted by a freestanding rehabilitation hospital was for a patient solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again). The OIG will ask providers to disclose this information when requesting documentation.

Review Guidelines:

1. Was the medical record received? (SSA §1815(a); 42 CFR §424.5(a)(6))

   _____ Yes: continue review
   _____ No, assign **error code GAN01** for no documentation submitted. **End of Audit.**

2. Was the documentation for the correct beneficiary? (SSA §1815(a); 42 CFR §424.5(a)(6))

   _____ Yes: continue review
   _____ No, assign **error code GAI10** for documentation submitted for the incorrect beneficiary. **End of Audit.**

3. Was the documentation submitted for the correct dates of service under review? (SSA §1815(a); 42 CFR §424.5(a)(6))

   _____ Yes: continue review
   _____ No, assign **error code GAI11** for documentation submitted for the incorrect dates of service. **End of Audit.**

Pre-Admission Screening

4. Does the documentation include a preadmission screening? (42 CFR §412.622(a)(4)(i))

   _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

   _____Yes: proceed to next question

   _____No: assign **error code IRF2L** - The preadmission screen was not included in the submitted documentation; continue to next question

5. Does the documentation support that the preadmission screening was conducted or updated within 48 hours of admission? (42 CFR §412.622(a)(4)(i)(A))
   Note: *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 update the patient's medical and functional status within the 48 hours immediately preceding the IRF admission and is documented in the patient's medical record.(42 CFR §412.622(a)(4)(i)(A))*

   _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

   _____Yes: proceed to next question

   _____No: assign **error code IRF2A -** Documentation does not support the preadmission screen was conducted or updated within the 48 hours immediately preceding the IRF admission; continue to next question

6. Does the documentation support that the rehabilitation physician concurred with the findings and results of the preadmission screening prior to the IRF admission? (42 CFR §412.622(a)(4)(i)(D))

   _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

   _____Yes: proceed to next question

   _____No: assign **error code IRF2B** - Documentation does not support the rehabilitation physician concurred with the findings and results of the preadmission screening; continue to next question

7. Does the preadmission screening documentation include the patient's level of function prior to the event or condition that led to the patient's need for intensive rehabilitation therapy? (42 CFR §412.622(a)(4)(i)(B))

   _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

   _____Yes: proceed to next question

   _____No: assign **error code IRF2C -** Documentation does not support the preadmission screen included the patient's level of function prior to the event or condition that led to the patient's need for intensive rehabilitation therapy; continue to next question

8. Does the preadmission screening documentation include the patient's expected level of improvement? (42 CFR §412.622(a)(4)(i)(B))

   _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

   _____Yes: proceed to next question

   _____No: assign **error code IRF2E -** Documentation does not support the preadmission screen included the patient's expected level of improvement; continue to next question

9. Does the preadmission screening documentation include the patient's expected length of time necessary to achieve that level of improvement? (42 CFR §412.622(a)(4)(i)(B))

   _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

   _____Yes: proceed to next question

   _____No: assign **error code IRF2D -** Documentation does not support the preadmission screen included the patient's expected length of time to achieve documented expected level of improvement; continue to next question

10. Does the preadmission screening documentation include the patient's anticipated discharge destination from the IRF stay? (42 CFR §412.622(a)(4)(i)(B))

    _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

    _____Yes: proceed to next question

_____No: assign **error code IRF2F -** Documentation does not support the preadmission screen included the patient's anticipated discharge destination from the IRF stay; continue to next question

11. Does the preadmission screening documentation include the patient's condition(s) that caused the need for rehabilitation? (42 CFR §412.622(a)(4)(i)(B))

    _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

    _____Yes: proceed to next question

    _____No: assign **error code IRF2I -** Documentation does not support the preadmission screen included the conditions that caused the need for rehabilitation; continue to next question

12. Does the preadmission screening documentation include the patient's treatments needed (i.e., physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics)? (42 CFR §412.622(a)(4)(i)(B))

    _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

    _____Yes: proceed to next question

    _____No: assign **error code IRF2J -** Documentation does not support the preadmission screen included the treatments needed (i.e., physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics); continue to next question

13. Does the preadmission screening documentation include an evaluation of the patient's risk for clinical complications? (42 CFR §412.622(a)(4)(i)(B))

    _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

    _____Yes: proceed to next question

    _____No: assign **error code IRF2H -** Documentation does not support the preadmission screen included an evaluation of the patient's risks for clinical complications; continue to next question

Plan of Care

14. Does the documentation include an overall plan of care? (42 CFR §412.622(a)(4)(ii))

    _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

    _____Yes: proceed to next question

    _____No: assign **error code IRF1H** - Documentation did not include an individualized overall Plan of Care (POC); continue to next question

15. Does the documentation support that the overall plan of care was developed within 4 days of admission to IRF? (42 CFR §412.622(a)(4)(ii)(A))

    _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

    _____Yes: proceed to next question

    _____No: assign **error code IRF1A -** Documentation does not support the individualized Plan of Care (POC) was developed within 4 days of admission to IRF; continue to next question

16. Does the documentation support that the overall plan of care was developed by a rehabilitation physician with input from the interdisciplinary team? (42 CFR §412.622(a)(4)(ii)(A))

    _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

    _____Yes: proceed to next question

    _____No: assign **error code IRF1G** – Documentation does not support that the individualized overall plan of care was developed by a rehabilitation physician with input from the interdisciplinary team; continue to next question

17. Does the documentation support that the plan of care was individualized? (42 CFR §412.622(a)(4)(ii)(A))

    _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

    _____Yes: proceed to next question

_____No: assign **error code IRF1B** – Documentation does not support that the plan of care was individualized; continue to next question

Interdisciplinary Team Approach to Care/Weekly Interdisciplinary Team Meetings

18. Does the documentation include the results and findings of each interdisciplinary team meeting? (42 CFR §412.622(a)(5)(iii))

    _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

    _____Yes: proceed to next question

    _____No: assign **error code IRF4A -** Documentation does not include the results and findings of each interdisciplinary team meeting; continue to next question

19. Does the documentation support that the Interdisciplinary Team meetings occurred at least once per week throughout the stay? (42 CFR §412.622(a)(5)(ii))

    _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

    _____Yes: proceed to next question

    _____No: assign **error code IRF4B** - Documentation did not consistently support the minimum frequency requirement was met for interdisciplinary team meetings. Interdisciplinary team meetings were not held at a minimum of once per week throughout the stay; continue to next question

20. Does the documentation support that a rehabilitation physician led each interdisciplinary team meeting throughout the IRF stay? (42 CFR §412.622(a)(5)(i))
    ***Note**: The rehabilitation physician may lead the interdisciplinary team meeting remotely via a mode of communication such as video or telephone conferencing. (42 CFR §412.622(a)(5)(i))*

    Note: Reviewer to document the reason for denial, date(s), and missing team member(s)

    _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

    _____Yes: proceed to next question

    _____No: assign **error code IRF4D** - Documentation does not support that each interdisciplinary meeting was led by a rehabilitation physician; continue to next question

21. Does the documentation support that all required participants (rehabilitation physician, rehabilitation registered nurse, social worker and/or case manager, licensed or certified therapist from each therapy discipline involved in treating the patient)) attended each interdisciplinary team meeting throughout the IRF stay? (42 CFR §412.622(a)(5)(i))

    Note: Reviewer to document the reason for denial, date(s), and missing team member(s)

    _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

    _____Yes: proceed to next question

    _____No: assign **error code IRF4C** - The documentation did not support that all required participants (rehabilitation physician, rehabilitation registered nurse, social worker and/or case manager, licensed or certified therapist from each therapy discipline involved in treating the patient) attended each interdisciplinary team meeting throughout the IRF stay; continue to next question

22. Does the documentation support that at each interdisciplinary team meeting the team reviewed the patient's progress toward stated rehabilitation goals and identified any problems that could impede progress toward those goals? (42 CFR §412.622(a)(5)(ii))

    Note: Reviewer to document the reason for denial and date(s)

    _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

    _____Yes: proceed to next question

    _____No: assign **error code IRF4G** - The interdisciplinary team meeting notes do not address goal progress and/or any problems impeding goal progress; continue to next question

23. Does the documentation include the concurrence by the rehabilitation physician with the results and findings of each interdisciplinary team meeting? (42 CFR §412.622(a)(5)(iii))

    _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

    _____Yes: proceed to next question

    _____No: assign **error code IRF4H -** Documentation does not include the concurrence by the rehabilitation physician with the results and findings of each interdisciplinary team meeting; continue to next question

Medical Necessity/Coverage Criteria

24. Does the documentation support that upon admission to the IRF there was a reasonable expectation that the patient required active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy, one of which must be physical therapy or occupational therapy? (42 CFR §412.622(a)(3)(i))

    Note: Reviewer to document for each therapy discipline

    _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

    _____Yes: proceed to next question

    _____No: assign **error code IRF5C** - Documentation does not support that upon admission to the IRF there was a reasonable expectation that the patient required active and ongoing multiple therapy disciplines (one of which must be physical therapy or occupational therapy); continue to next question

25. Does the documentation support that upon admission to the IRF there was a reasonable expectation that the patient was sufficiently stable to be able to actively participate in a rehabilitation therapy program? (42 CFR §412.622(a)(3)(iii))

    _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

    _____Yes: proceed to next question

    _____No: assign **error code IRF5D -** Documentation does not support that upon admission to the IRF there was a reasonable expectation that the patient was sufficiently stable to be able to actively participate in a rehabilitative program; continue to next question

26. Does the documentation support that upon admission to the IRF there was a reasonable expectation that the patient required physician supervision by a rehabilitation physician? (42 CFR §412.622(a)(3)(iv))

    _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

    _____Yes: proceed to next question

_____No: assign **error code IRF5A -** Documentation does not support that upon admission to the IRF there was a reasonable expectation that the patient required the physician supervision by a rehabilitation physician; continue to next question

27. Does the documentation support that the rehabilitation physician conducted 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? (42 CFR §412.622(a)(3)(iv))

    Note: *During [the COVID-19 Public Health Emergency] such visits may be conducted using telehealth services. (42 CFR §412.622(a)(3)(iv))*

    Note: *Beginning with the second week of admission to the IRF, a non-physician practitioner 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. (42 CFR §412.622(a)(3)(iv))*

    _____N/A: the patient was being furnished care in a freestanding IRF hospital solely to relieve acute care hospital capacity in a state (or region, as applicable) that is experiencing a surge (i.e., in phase 1 of the President's Guidelines for Opening Up America Again) during the COVID-19 PHE; proceed to next question

    _____Yes: proceed to next question

    _____No: assign **error code IRF5G -** Documentation does not support that the rehabilitation physician conducted face-to-face visits with the patient at least 3 days per week throughout the patient's stay in the IRF; continue to next question

Therapy Disciplines

28. Does documentation support that the patient received rehabilitation therapy services? (SSA §1815(a); 42 CFR §424.5(a)(6); 42 CFR §412.622(a)(3))

    Note: Reviewer to document for each therapy discipline

    _____Yes: proceed to next question

    _____No: assign **error code IRF8B -** Documentation does not support that the patient received rehabilitation therapy services; continue to next question

Billing and/or Coding

29. Does the documentation support that a clinician of the inpatient rehabilitation facility performed a comprehensive, accurate, standardized, and reproducible assessment of the patient? (42 CFR §412.606(b))

    _____Yes: proceed to next question

_____No: assign **error code IRF7C -** The documentation did not contain a required Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI); continue to next question

30. Was the admission assessment completed by the fourth calendar date of the admission? (42 CFR §412.610(c)(1))

    _____Yes: proceed to next question

    _____No: assign **error code TBD;** continue to next question

31. Was the discharge assessment completed on the 5th calendar day that follows the date the patient is discharged or stops being furnished Medicare Part A fee-for-service inpatient rehabilitation services? (42 CFR §412.610(c)(2))

    _____Yes: proceed to next question

    _____No: assign **error code TBD;** and continue to next question

32. Does the documentation support the primary condition/diagnosis reported on the claim? (42 CFR §412.620(a))

    _____ Yes, proceed to next question
    _____ No, assign **error code GAK15** - Incorrect Coding; continue to next question

33. Does the documentation support the comorbid conditions reported on the claim? (42 CFR §412.620(a))

    Note: *Comorbidity means a specific patient condition that is secondary to the patient's principal diagnosis that is the primary reason for the inpatient rehabilitation stay. (42 CFR §412.602)*

    _____ Yes, proceed to next question
    _____ No, assign **error code GAK15**- Incorrect Coding; continue to next question

34. Does the documentation support the age of the beneficiary reported on the claim? (42 CFR §412.620(a))

    _____ Yes, proceed to next question
    _____ No, assign **error code 3100** - Incorrect Coding and continue to next question

35. Does the documentation support the motor and cognitive skills reported on the claim? (42 CFR §412.620(a))

    _____ Yes, proceed to next question
    _____ No, assign **error code 3100** - Incorrect Coding; continue to next question

36. Does the documentation support an interrupted stay occurred and a separate payment was made? (42 CFR §412.602; 42 CFR §412.618; 42 CFR §412.624(g))

Note: *Interrupted stay means a stay at an inpatient rehabilitation facility during which a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The duration of the interruption of the stay of 3 consecutive calendar days begins with the day of discharge from the inpatient rehabilitation facility and ends on midnight of the third day. (42 CFR §412.602)*

Note: *The clinician must record the interruption of the stay on the patient assessment instrument. (42 CFR §412.618)*

Note: *When a patient in an inpatient rehabilitation facility has one or more interruptions in the stay, as defined in § 412.602 and as indicated on the patient assessment instrument in accordance with § 412.618(b), CMS will make payments in the following manner:*

(1) Patient is discharged and returns on the same day. Payment for a patient who is discharged and returns to the same inpatient rehabilitation facility on the same day will be the adjusted Federal prospective payment under paragraph (e) of this section that is based on the patient assessment data specified in § 412.618(a)(1). Payment for a patient who is discharged and returns to the same inpatient rehabilitation facility on the same day will only be made to the inpatient rehabilitation facility.

(2) Patient is discharged and does not return by the end of the same day. Payment for a patient who is discharged and does not return on the same day but does return to the same inpatient rehabilitation facility by or on midnight of the third day, defined as an interrupted stay under § 412.602, will be–

(i) The adjusted Federal prospective payment under paragraph (e) of this section that is based on the patient assessment data specified in § 412.618(a)(1) made to the inpatient rehabilitation facility; and

(ii) If the reason for the interrupted patient stay is to receive inpatient acute care hospital services, an amount based on the prospective payment systems described in § 412.1(a)(1) made to the acute care hospital. (42 CFR §412.624(g))

_____Yes: assign **error code 6000 –** Unbundling; continue to next question

_____No: proceed to next question

37. Does the documentation support a short-stay admission occurred? (42 CFR §412.620(b)(2); MCPM Ch 3 §§ 140.2.4 and 140.3)

Note: *The IRF PPS also includes a payment adjustment for certain cases, such as short-stay cases (for cases that do not meet the definition of a transfer case). A separate CMG payment (5001) will be made for cases with a length of stay of 3 days or less, without consideration of the clinical characteristics of the patient. Cases that expire with a length of stay of 3 days or less, will also be classified to CMG 5001. (*MCPM Ch 3 §140.2.4)

Note: *For atypical cases effective January 1, 2010, the HCPCS/Rates must contain a five digit HIPPS Rate/CMG Code A5001. An atypical case occurs under the new IRF coverage requirements that became effective January 1, 2010, where an IRF is eligible to receive the IRF short stay*

payment for 3 days or less (HIPPS Rate/CMG A5001) if a patient's thorough preadmission screening shows that the patient is an appropriate candidate for IRF care but then something unexpected happens between the preadmission screening and the IRF admission such that the patient is no longer an appropriate candidate for IRF care on admission and the day count is greater than 3. In this scenario only, if the patient is discharged/transferred on or after day 4, we are instructing IRFs to bill HIPPS Rate/CMG A5001. Thus, whether or not the IRF is able to discharge the patient to another setting of care within 3 days, the IRF will only be eligible for and receive the IRF short stay payment for 3 days or less (HIPPS Rate/CMG A5001). (MCPM Ch 3 §140.3)

_____Yes: HIPPS code A5001 billed, **End of Audit**

_____Yes: HIPPS code A5001 not billed, assign **error code [TBD] -** Documentation does not support that the patient was discharged from the Inpatient Rehabilitation Facility (IRF) within three days of admission when there were relevant changes in the patient's status that deemed the patient to not be an appropriate candidate for IRF level of care. The Health Insurance Prospective Payment System (HIPPS) code was changed to A5001, **End of Audit**

_____No: **End of Audit**

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APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

Our sampling frame consisted of 300,269 Medicare IRF claims totaling $7,046,305,401 paid to IRFs for services provided during our audit period. The frame included claims that: (1) were paid under the IRF PPS from the Medicare Trust Fund to an inpatient rehabilitation hospital or to a rehabilitation unit of an acute-care hospital and (2) had a value of $1,000 or more.

SAMPLE UNIT

The sample unit was a Medicare-paid IRF claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample. We grouped the sampling frame into strata based on claim paid amount, as shown in Table 1.

Table 1: Sample Size and Frame Description

Stratum	Medicare Claim Type	Number of Claims in Frame	Total Payment Amount in Frame	Sample Size
1	IRF claims less than $23,812.44	173,336	$2,992,201,324	100
2	IRF claims at least $23,812.44	126,933	4,054,104,077	100
	Total	**300,269**	**$7,046,305,401**	**200**

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OAS) statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We sorted the claims within each stratum by a unique claim identifier and then consecutively numbered the claims in each stratum in the sampling frame. After generating random numbers in accordance with our sample design, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total overpayment amount for IRF claims in the sampling frame and to calculate a point estimate and a two-sided 90-percent confidence interval.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Details and Results

Stratum	Frame Size (Claims)	Value of Frame	Sample Size	Value of Sample	Number of Deficiencies in Sample	Value of Overpayments in Sample
1	173,336	$2,992,201,324	100	$1,766,629	86	$1,454,583
2	126,933	4,054,104,077	100	3,262,706	72	1,962,033
Total	**300,269**	**$7,046,305,401**	**200**	**$5,029,335**	**158**[55]	**$3,416,616**

Table 3: Estimated Value of Overpayments in the Sampling Frame
(Limits Calculated at the 90-Percent Confidence Level)

Point estimate	$5,011,783,725
Lower limit	$4,610,791,658
Upper limit	$5,412,775,793

[55] For 11 of the 158 deficiencies, the related requirements were not a condition of payment.

APPENDIX E: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: March 12, 2026

TO: Megan Tinker
Chief of Staff
Office of Inspector General

FROM: Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: Unclear Medicare Requirements Led to Differing Interpretations of Inpatient Rehabilitation Facility Documentation, Coverage, and Billing Requirements (A-04-23-08096)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

A 2018 OIG report on inpatient rehabilitation facilities (IRFs) found that 175 of 200 IRF stays did not meet Medicare requirements. Based on these findings, OIG estimated that Medicare paid IRFs $5.7 billion (84 percent of the dollars covered by the audit) for care that did not meet Medicare requirements. As stated in OIG's current report, IRF stakeholders questioned the OIG's methodology, strict interpretation of regulatory requirements, and what the IRF stakeholders perceived as second guessing the physicians involved in the care of IRF patients. This current report sought to determine the root cause of the varying interpretations of IRF regulations by OIG, IRF stakeholders, and CMS.

In this current report, OIG determined that 158 of 200 sampled IRF claims did not comply with Medicare requirements. Based on these findings, OIG estimates that Medicare paid IRFs approximately $5 billion (71 percent of the dollars covered by the audit) for claims that did not meet Medicare requirements. In contrast, IRF stakeholders reviewed the claims that OIG identified as not meeting Medicare requirements and reported an error rate in "the high teens to low twenties." CMS reviewed 19 claims that OIG believed to be in error but IRF stakeholders believed to be in compliance and found that 14 of the 19 met Medicare requirements.

The OIG's report details ten agreed upon review criteria. For the cases discussed, OIG believed that for each criterion, the Medicare requirements were not met. IRF stakeholders believed that for each criterion, the Medicare requirements were met. CMS found that Medicare requirements were met for 9 of the 10 criteria.

Based on the collaborative medical record review and subsequent discussions, CMS believes that the OIG's findings and perceived risks may be overstated. It should be noted that the most recent improper payment rate for IRFs as reported by the Comprehensive Error Rate Testing (CERT) program was 21.5 percent with a projected improper payment amount of $1.6 billion.[1] This

[1] CMS implemented the CERT program to measure improper payments in the Medicare FFS program. The FY 2025 Medicare FFS improper payment rate included claims submitted during the 12-month period from July 1, 2023

varies significantly from OIG's findings in this report. Regardless of this discrepancy, CMS is committed to promoting compliance with Medicare requirements and reducing improper payments for IRF services.

CMS recognizes the importance of providing Medicare beneficiaries with access to medically necessary services, while also working to protect the Medicare Trust Funds from improper payments. CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing systems, and conducting prepayment and post-payment reviews. As part of this strategy, CMS recovers identified overpayments in accordance with agency policies and procedures. For example, in response to the OIG's 2018 report on IRF services, CMS instructed the Supplemental Medical Review Contractor (SMRC) to conduct a review. As such, the SMRC conducted a post-payment review of claims for IRF services billed for dates of service in 2018 and found an error rate of 33 percent.[2] Providers received detailed denial reasons when an overpayment was determined, and provider education was available.

CMS has also approved the Medicare Administrative Contractors (MACs) to perform reviews of inpatient rehabilitation providers under its Targeted Probe and Educate (TPE) program.[3] This program includes one-on-one education to reduce claim errors and denials for providers who have high denial rates or unusual billing practices. The level of educational intervention increases depending on the claim denial rates. There is also an approved Recovery Audit Contractor (RAC) review for complex medical reviews of IRFs to confirm compliance with medical necessity and documentation requirements.[4]

Additionally, CMS has established the Review Choice Demonstration (RCD) for IRF services. Under the RCD, IRF providers in selected states choose how to demonstrate their compliance with Medicare IRF requirements. After a 6-month period, IRFs demonstrating compliance with Medicare rules through their pre-claim review affirmation rate or post-payment review approval rate have additional review choices to select from. This program reduces the number of Medicare appeals, improves IRF provider compliance with Medicare program rules, does not alter the Medicare IRF benefit, and should not delay care to Medicare beneficiaries. The program is currently active in Alabama and Pennsylvania. CMS has announced that the RCD for IRF services will be expanding to Texas and California in 2026.[5]

Further, CMS has taken actions to educate health care providers on the proper billing for inpatient rehabilitation services. CMS educates health care providers on avoiding Medicare billing errors through various channels including the Medicare Learning Network (MLN), weekly electronic newsletters, and quarterly compliance newsletters. For example, CMS maintains a webpage with Medicare compliance tips for inpatient rehabilitation hospitals

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through June 30, 2024. Information about the 2025 Medicare FFS improper payment rate is available at: https://www.cms.gov/files/document/nov-2025-medicare-ffs-supplemental-improper-payment-data-2025922.pdf

[2] Additional information on the SMRC review is available at: https://noridiansmrc.com/completed-projects/01-025/

[3] Additional information on the TPE program is available at: https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/medical-review-and-education/targeted-probe-and-educate-tpe

[4] Additional information on the RAC review is available at: https://www.cms.gov/research-statistics-data-and-systems/monitoring-programs/medicare-ffs-compliance-programs/recovery-audit-program/approved-rac-topics-items/0073-inpatient-rehabilitation-facility-irf-stays-meeting-requirements-to-be-considered-reasonable-and-necessary-

[5] Additional information on the Review Choice Demonstration for IRF Services is available at: https://www.cms.gov/data-research/monitoring-programs/medicare-fee-service-compliance-programs/prior-authorization-pre-claim-review-initiatives/review-choice-demonstration-inpatient-rehabilitation-facility-services#background

inpatient rehabilitation units, which includes information on common denial reasons and tips for preventing denials.[6] CMS also maintains a MLN educational tool with information about the IRF Prospective Payment System.[7] CMS has published a MLN Matters regarding IRF Medical Review Changes.[8] CMS has also published an MLN Matters to highlight updates to Chapter 1, Section 110 of the Medicare Benefit Policy Manual regarding IRF Services.[9] CMS has also hosted webinars to discuss IRF coverage requirements.[10] Lastly, CMS maintains a provider resource mailbox specifically for IRFs, through which we provide responses to a wide range of questions related to proper billing and other issues.

The OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that CMS revise or clarify IRF documentation requirements related to the: (1) development and individualization of the POC, (2) leadership of IDT meetings by rehabilitation physicians, (3) review at IDT meetings of enrollee progress toward rehabilitation goals and identification of any problems that could impede such progress, and (4) functional status of enrollees during the preadmission screening.

CMS Response

CMS does not concur with this recommendation. As stated above, CMS generally found that the Medicare requirements were met. Therefore, revisions or clarifications of the IRF documentation requirements are not warranted based on the OIG's findings. The issues raised by OIG in this report related to this recommendation would be best addressed through education. CMS will continue to educate health care providers on Medicare requirements, including IRF documentation requirements, to assist with compliance.

OIG Recommendation

The OIG recommends that CMS revise or clarify IRF coverage requirements to define: (1) what constitutes a reasonable expectation that an enrollee requires supervision by a rehabilitation physician, (2) what it means to have active and ongoing therapeutic intervention from multiple disciplines, and (3) what it means to be sufficiently stable to actively participate in an intensive rehabilitation therapy program.

CMS Response

CMS does not concur with this recommendation. As stated above, CMS generally found that the Medicare requirements were met. Therefore, revisions or clarifications of the IRF coverage requirements are not warranted based on the OIG's findings. The issues raised by OIG in this report related to this recommendation would be best addressed through education. CMS will continue to educate health care providers on Medicare requirements, including IRF coverage requirements to assist with compliance.

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[6] Additional information available at: https://www.cms.gov/training-education/medicare-learning-networkr-mln/compliance/medicare-provider-compliance-tips/inpatient-rehabilitation-hospitals

[7] Additional information available at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/html/medicare-payment-systems.html#Inpatient2

[8] MLN Matters – Inpatient Rehabilitation Facility (IRF) Medical Review Changes (December 2018). https://www.cms.gov/sites/default/files/repo-new/26/se17036_0.pdf

[9] MLN Matters – Internet Only Manual Updates to Publication (Pub.) 100-02 to Implement Updates to Policy and Correct Errors and Omissions (Inpatient Rehabilitation Facility (IRF)) (August 2021). https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c01.pdf https://www.cms.gov/files/document/mm12353.pdf, Pub 100-02 Medicare Benefit Policy Manual, Chapter 1.

[10] Medicare Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS): Coverage Requirements Webinar (November 2023). https://www.cms.gov/files/document/irf-pps-coverage-requirements-webinar-11/2023.pdf

OIG Recommendation
The OIG recommends that CMS revise or clarify IRF-PAI signature requirements.

CMS Response
CMS does not concur with this recommendation. The IRF Patient Assessment Instrument (IRF-PAI) Manual includes a chapter that provides guidance regarding the signatures of persons completing the assessment.[11] CMS found that the Medicare requirements for this requirement were met. Therefore, revisions or clarification of the IRF-PAI signature requirements are not warranted based on the OIG's findings. The issues raised by OIG in this report related to this recommendation would be best addressed through education. CMS will continue to educate health care providers on Medicare requirements, including IRF-PAI signature requirements.

OIG Recommendation
The OIG recommends that CMS offer training and learning sessions to assist with regulation compliance.

CMS Response
CMS concurs with this recommendation. CMS will continue to educate providers on Medicare requirements.

[11] The IRF-PAI and IRF-PAI Manual are available at: https://www.cms.gov/medicare/quality/inpatient-rehabilitation-facility/irf-pai-and-irf-qrp-manual.

APPENDIX F: INPATIENT REHABILITATION FACILITIES STAKEHOLDERS' COMMENTS

AAPM&R, AMRPA, and FAH Response to 2026 OIG Report on Inpatient Rehabilitation Hospitals and Units: A-04-23-08096

The American Academy of Physical Medicine and Rehabilitation ("AAPM&R"), the American Medical Rehabilitation Providers Association ("AMRPA"), and the Federation of American Hospitals ("FAH") (hereinafter "the Stakeholders")[1] thank the Office of Inspector General ("OIG") for the opportunity to respond to its draft report entitled, *"Unclear Medicare Requirements Led to Differing Interpretations of Inpatient Rehabilitation Facility Documentation, Coverage, and Billing Requirements."*[2] We appreciate the willingness of OIG to engage with the Stakeholders throughout the course of this audit and the opportunity to discuss key clinical and regulatory distinctions in the care provided in inpatient rehabilitation hospitals and units, commonly referred to by Medicare as Inpatient Rehabilitation Facilities ("IRFs"), and believe the process has been constructive. OIG and the Stakeholders share the same goal of ensuring that Medicare beneficiaries in need of inpatient rehabilitation hospital services receive safe, high quality, and cost-effective care. At the same time, we hope to improve the efficacy of the claims review process for all concerned including patients, health care providers, and the Medicare program.

I. Executive Summary

The following points summarize our response to OIG's draft report:

- This draft report reinforces what IRFs have consistently conveyed to the Centers for Medicare and Medicaid Services ("CMS") and its contractors over many years. ***The vast majority of IRF compliance issues reflect good-faith differences in interpretation of medical necessity and documentation requirements, rather than clear noncompliance or fraud.***
- The Stakeholders remain concerned that documentation standards are often applied in an unusually narrow manner in the IRF setting. In this audit, errors identified by the OIG contractor were tied to compliance with 37 separate documentation and coverage elements for each Medicare beneficiary—standards that apply to stays averaging two to three weeks and involving intensive, interdisciplinary rehabilitation care. Given the clinical complexity of these patients and the coordinated nature of IRF services, differences in interpretation can understandably arise due to the ambiguity of some of the regulations and government contractors' narrow reading of the regulatory requirements.
- Because the identified errors largely reflect differences in clinical and documentation interpretation, the Stakeholders do not believe an extrapolated overpayment estimate based

[1] AAPM&R is the national medical specialty organization representing more than 10,000 board-certified physicians who are specialists in physical medicine and rehabilitation. AMRPA is a national trade association representing more than 800 IRFs, which include freestanding inpatient rehabilitation hospitals, rehabilitation units within acute care hospitals, as well as rehabilitation units within long-term care hospitals. FAH is the national representative of more than 1,000 tax-paying community hospitals and health systems, including many IRFs.

[2] OIG, U.S. Dep't of Health & Hum. Servs., Unclear Medicare Requirements Led to Differing Interpretations of Inpatient Rehabilitation Facility Documentation, Coverage, and Billing Requirements, No. A-04-23-08096 (2026) (hereinafter "OIG Report").

on the contractor's error rate would be appropriate or methodologically sound for inclusion in the final report. Our full concerns with any extrapolation are detailed on page four.

- Data shows that differing interpretations of CMS regulatory policy have not had a measurable impact on the quality of care provided by IRFs. Well-defined quality metrics for IRF care demonstrate that IRFs provide high quality care to patients, discussed further on pages four and five.
- The Stakeholders support OIG's recommendations to CMS and offer commentary on their implementation, as well as additional recommendations to CMS to clarify and simplify IRF coverage and documentation standards while placing greater emphasis on the judgment of the rehabilitation physician. Our responses to OIG's recommendations begin on page seven. We hope to continue working with OIG and CMS to achieve these goals.

II. Introduction

The collaborative approach to this audit developed after the Stakeholders voiced concerns with OIG's 2018 audit of the IRF field,[3] which found an extremely high error rate that vastly exceeded estimated error rates from other government audits.[4] Acknowledging this disconnect, OIG engaged with the Stakeholders throughout this subsequent nationwide IRF audit with the goal of identifying "root causes of the varying interpretations of IRF regulations" through the review of real-life patient cases, understanding the high patient acuity and complexity of care delivered in IRFs. The intent was to identify recommendations to clarify and streamline medical necessity and documentation requirements to assess the propriety of IRF admissions more accurately.

The IRF Stakeholders provided feedback to OIG on its sampling methodology to identify a sample of 200 patient cases with dates of service in 2022,[5] commented on the 37-question Medical Review Instrument ("MRI") used by its contractor to audit the claims, and reviewed the medical records of all claims deemed by the contractor to contain errors. The Stakeholders assembled a volunteer team of twenty physicians board-certified in physical medicine and rehabilitation ("PM&R") and ten rehabilitation therapists. Each patient file, which ranged from 500 to over 2,000 pages, was reviewed by at least two (and often more) team members.

Because the stated purpose of this collaboration was to "determine the root causes of the varying interpretations of IRF regulations," a core clinical review committee comprised of PM&R physicians and therapists selected 19 patient cases to highlight points of contention with specific "errors" alleged by the OIG contractor. Those cases were discussed at length with OIG and its contractor in a two-day, in-person meeting, with CMS observing these discussions. The cases were selected by the Stakeholders to illustrate the types of varying interpretations IRFs often confront when government auditors review their claims. CMS subsequently reviewed the medical records of each of the 19 cases discussed and agreed with the Stakeholders in 14 of 19 instances.[6]

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[3] OIG, U.S. Dep't of Health & Human Servs., No. A-01-15-00500, Many Inpatient Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements (2018).

[4] For example, in OIG's 2018 IRF audit report, the error rate identified for 2013 claims was nearly five times higher than the IRF error rate for 2013 found by CMS' Comprehensive Error Rate Testing ("CERT") contractor, the entity that determines error rates by provider type for CMS. *See* CMS, Medicare Fee-For-Service 2013 Improper Payments Report 22 (2013), medicarefee-for-service2013improperpaymentsreport.pdf.

[5] The sample occurred during the COVID public health emergency.

[6] In some of these cases, CMS suggested that additional errors were present in the medical record.

This rate of concurrence between CMS and the Stakeholders and discord with OIG's contractor is reflected in OIG's finding that differing interpretations of often unclear Medicare requirements were the primary reason for the error rate (and the related extrapolation of Medicare payments) found by OIG. As indicated by the title of the report itself, "errors" identified in the report do not indicate fraud by IRFs,[7] but rather good faith disagreements between auditors and IRFs as to the medical necessity of inpatient rehabilitation hospital care or other technical compliance requirements. The audit underscores the challenges of applying detailed regulatory standards to patients receiving individualized rehabilitation hospital services. Even acknowledging that a smaller subset of patient files did not satisfy some of the detailed documentation requirements, the differing interpretations in the audit should not obscure that beneficiaries received medically necessary rehabilitation services that improved function and recovery.

III. The Value of Rehabilitation Care Provided by IRFs

IRFs enable patients to recover from illness, injury, or disability and regain functional abilities to live as independently as possible. IRFs provide medical management and physician-supervised intensive rehabilitation therapy programs that consist of physical and occupational therapy, speech-language pathology, prosthetic/orthotic services, rehabilitation nursing, and a wide variety of related services designed to improve function. Patients treated in the IRF setting have diverse and complex medical needs. Common conditions treated in IRFs include strokes and other neurological conditions, brain injuries, fractures of the lower extremities and other orthopedic conditions, cardiac conditions, spinal cord injuries, limb amputations, and major joint replacements of the lower extremities.[8]

IRFs provide highly effective, hospital-level rehabilitation care that includes intensive, interdisciplinary, coordinated medical management and rehabilitation therapies that produce patient outcomes that are significantly better than in lower-intensity levels of care, such as skilled nursing facilities ("SNFs"). When compared to similar patients who received rehabilitation in SNFs, IRF patients had better long-term clinical outcomes, returned home earlier, remained home longer, visited the emergency room less frequently, were often less likely to be readmitted to the hospital, and lived longer.[9] This is why evidence-based guidelines categorically recommend that certain patients with particular critical diagnoses receive immediate IRF care.[10] As OIG recognizes, IRFs receive higher Medicare payment rates because they are statutorily designed to furnish intensive, coordinated, interdisciplinary rehabilitation care that goes beyond an acute care hospital level of services and is delivered over an average two-week inpatient stay.[11]

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[7] At no place in the report is there evidence or any accusation of fraud.
[8] MedPAC, Report to Congress: Medicare Payment Policy 264 (2023), https://www.medpac.gov/wp-content/uploads/2023/03/Mar23_MedPAC_Report_To_Congress_v2_SEC.pdf.
[9] Dobson DaVanzo & Assocs., LLC, *Assessment of Patient Outcomes of Rehabilitative Care Provided in Inpatient Rehabilitation Facilities (IRFs) and After Discharge*, E-3 (2014), https://www.dobsondavanzo.com/clientuploads/Publications/Cohort_Comparison/Assessment_of_Patient_Outcomes_of_Rehabilitation_Care_2014.pdf.
[10] *See* William J. Powers, et al., *2018 Guidelines for the Early Management of Patients with Acute Ischemic Stroke: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association*, 49 STROKE e46 (2018), http://stroke.ahajournals.org/content/49/3/e46.
[11] OIG Report at 2.

IV. Stakeholder Responses to OIG's Findings

The IRF Stakeholders set forth the following responses to the OIG's findings and recommend the following revisions to the draft audit report.

A. Stakeholder Response to OIG's "Error Rate" and Extrapolation

OIG states in its report that its audit was not designed "to report an IRF claims error rate or to recommend recovery of improperly paid claims."[12] Despite this statement, the report does include the OIG's extrapolated overpayment amount based on the value of claims found by the contractor to contain payment errors. ***The IRF Stakeholders believe it is inappropriate for OIG to publish in its report an extrapolation of the dollar value of the error rate found by its contractor because many of its adverse findings were contradicted by both CMS and the Stakeholders, raising serious concerns about the validity and accuracy of the contractor's findings.*** As such, the OIG contractor's findings should not be imputed to the entire universe of Medicare IRF claims, as any purported error rate or related extrapolation would be highly misleading.

This error rate differs markedly from audits conducted by several CMS contractors, particularly CMS's Comprehensive Error Rate Testing ("CERT") contractor. For instance, the 2025 CERT audit found an error rate of 21.5 percent for IRFs.[13] In addition, the Stakeholders have reported for years that the vast majority of denials are overturned through the administrative appeals process in favor of the IRF. Even "errors" agreed upon by OIG, CMS, and the Stakeholders do not indicate that the care provided in IRFs was medically unnecessary. Many of the errors identified by OIG's contractor were technical, documentation-related errors that do not impact patient care or outcomes. Indeed, 33 of the 37 questions in the MRI used by OIG's auditor to evaluate the claims pertained to non-medical necessity, technical aspects of IRF documentation and payment requirements.

The differing conclusions among OIG, CMS, and the Stakeholders—as well as variations between this report and other CMS audit findings—underscore the complexity of applying detailed IRF coverage and documentation standards. Identifying and examining these differences is consistent with the audit's purpose and provides an important opportunity to promote greater clarity, consistency, and alignment in how IRF care is evaluated under Medicare. Audits that do not accurately represent the care provided have real consequences for IRFs, compromising program integrity, undermining public confidence in inpatient rehabilitation hospitals and units, misleading policymakers, and jeopardizing patient access to a crucial service. The recommendations set forth by OIG, as well as additional recommendations offered by the Stakeholders in this response, lay the foundation for resolving these inconsistencies.

B. Quality of Care Concerns

We strongly disagree with the concern expressed by OIG in the draft report that differing interpretations of Medicare requirements by OIG, CMS, and the Stakeholders lead to inadequate quality of care in IRFs.[14] Demonstrating quality of care and meeting CMS requirements for payment are two distinct issues. The elements assessed by OIG in this audit have no material bearing on the quality of care provided in IRFs. Data shows that IRFs provided high quality care to

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[12] OIG Report at 1 n.3.
[13] U.S. Dep't of Health & Hum. Servs., 2025 Medicare Fee-for-Service Supplemental Improper Payment Data 7 (2025), https://www.cms.gov/files/document/nov-2025-medicare-ffs-supplemental-improper-payment-data-2025922.pdf.
[14] OIG Report at 5, 22.

patients before, during, and after the audit period, and that the potential differing interpretations of CMS regulatory policy have not had a measurable impact on the quality of care provided by IRFs.[15] IRFs continue to demonstrate high quality care and patient outcomes, including high rates of discharge to home, declining infection and complication rates, and sustained gains in functional recovery at discharge.[16]

C. Concerns Regarding Financial Loss to the Medicare Program

The OIG draft report also expresses concern that differing interpretations of Medicare requirements could lead to financial loss for the program.[17] We disagree that a single technical documentation "error" that does not relate to medical necessity warrants blanket nonpayment for the full duration of a patient's IRF stay. IRFs subject to this audit—and more broadly, all IRFs submitting claims to the Medicare program—must meet 37 different technical requirements on every single audit question/component of the regulations or have an entire payment for a multi-week IRF stay denied as a payment error. This is an excessively burdensome regulatory standard. We know of no other provider type, including other post-acute care providers, that must meet such a high bar for Medicare payment. OIG does not consider in its report the significant financial loss this standard imposes upon IRFs, which lose all payment for weeks-long stays over noncompliance with a single technical requirement. Further, when IRF providers appeal denials, they face a cumbersome and expensive appeals process to obtain payment for the care they provided, costs that are incurred by the Medicare program as well.

D. Conclusion that Medicare Regulations Are Unclear

OIG emphasizes throughout the report that lack of clarity in CMS regulations is the root cause of the differing conclusions by OIG, CMS, and the Stakeholders on whether the sampled claims meet Medicare requirements. ***While we agree that there are some areas where greater clarity in CMS regulations would be helpful, we do not believe more regulation is an effective solution.*** There are several instances where an inappropriately narrow interpretation of regulations by the OIG contractor was responsible for a sizable number of alleged payment errors. In our experience, this is typical of government contractors that audit IRFs, which tend to interpret CMS regulations as narrowly as possible. This is particularly problematic where government contractors such as Recovery Audit Contractors ("RACs") are paid based on the amount they recover for the Medicare program, creating an incentive to over-identify errors.

For instance, the draft OIG report noted payment errors where rehabilitation physicians were determined not to have "led" the rehabilitation team meetings despite evidence that they were present during the meetings, interacted with members of the rehabilitation teams, altered treatment plans during the meetings, concurred with suggested alterations to the treatment plans offered by clinical members of the rehabilitation teams, and explicitly signed the final team conference reports.

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[15] *See* CMS, Provider Data Catalog, Inpatient Rehabilitation Facilities Datasets, https://data.cms.gov/provider-data/search?theme=Inpatient%20rehabilitation%20facilities.

[16] For example, during the audit period, 67 percent of IRF patients successfully returned to home or the community, 62.1 percent were discharged at or above the expected functional level for self-care activities; and 61.2 percent were discharged at or above the expected functional level for mobility activities. Further, the percentage of IRFs who reported no infections or who had fewer infections than expected was 83 percent for catheter-associated urinary tract infection ("CAUTI") and 89 percent for *Clostridioides difficile* infection ("CDI"). Performance is higher for IRFs than other post-acute care settings reporting these measures. *See* CMS, Provider Data Catalog, Inpatient Rehabilitation Facilities Datasets, https://data.cms.gov/provider-data/search?theme=Inpatient%20rehabilitation%20facilities.

[17] OIG Report at 5, 22; *see also* cover page.

OIG's contractor employed a similar hyper-technical reading of the regulatory requirement for the rehabilitation physician to "develop" the individualized overall plan of care. In these instances, greater clarity on what documentation satisfies these regulatory requirements may be warranted, as detailed in our recommendations below.

However, in most instances, rather than further regulation, government auditors should give appropriate deference to rehabilitation physicians making clinical decisions as they are, by regulation, required to have specialized training and experience in inpatient rehabilitation. Medicare's coverage regulations rely heavily on the decision-making skills of highly trained rehabilitation physicians who bring years of clinical experience and consider patient-specific factors to determine the appropriateness of an IRF admission and an individualized plan of care. The coverage regulations emphasize the rehabilitation physician's judgment when admitting a patient to an IRF and do not create bright-line coverage rules that can be applied mechanically by auditors. This approach aligns with guidance by CMS to place more weight on the rehabilitation physician's decision to admit the patient to the IRF.[18]

CMS and the Stakeholders came to the same conclusion in 14 of the 19 cases we discussed, agreeing that the IRF met Medicare requirements on the OIG-identified error in question, which demonstrates that the issue is not always a general lack of clarity of the Medicare regulations, but a hyper-technical and narrow interpretation by government contractors that should be addressed by increased CMS education, supervision, and oversight of contractors.

V. Additional Factors That Contribute to Differing Interpretations of Audit Findings

Our review of the sampled cases revealed several additional factors that contributed to the differing interpretations of the audit findings. This includes:

- **Lack of Understanding of Physician-Led Rehabilitation Medicine:** Auditors often erroneously evaluate rehabilitation physicians as though they are practicing in a general acute care hospital. Rehabilitation physicians are not merely general practitioners or hospitalists practicing in an IRF. PM&R is a distinct medical specialty recognized by the American Board of Medical Specialties, and rehabilitation medicine is a distinct area of practice that focuses both on a patient's medical and rehabilitation needs. There are other medical specialties that also serve as rehabilitation physicians in IRFs. The goal of a rehabilitation physician practicing in an IRF is not just to stabilize a patient as in an acute care hospital. Rather, board-certified rehabilitation physicians and other physicians with specialized training and experience in inpatient rehabilitation ensure that a patient who has recently experienced a disabling injury or illness is able to participate in and benefit from rehabilitation. When audit methodologies reflect the interdisciplinary, hospital-based nature of IRF care, medical necessity determinations are more likely to accurately capture the need for inpatient rehabilitation services as is evidenced by the concurrence of CMS and Stakeholder reviewers. Patients participate in a rigorous program (*i.e.*, three hours of therapy per day, five days per week) where they might easily experience complications without the concurrent oversight of rehabilitation physicians. Rehabilitation physicians also initiate medications, order specialized equipment, and/or perform interventions that may facilitate one's functional recovery. Additionally, they are best suited to provide patient and caregiver education and answer questions regarding long-term prognoses.

[18] Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2010, 74 Fed. Reg. 39,762, 39,791 (Aug. 7, 2009).

- **A "bright-line" approach to complex medical reviews**: "Yes" or "no" questions used by OIG's contractor through the MRI fail to consider the totality of the clinical circumstances of any given case, including the complexity of IRF care, the inter-dependency of multiple members of the rehabilitation team, the multitude of conditions and comorbidities of highly compromised IRF patients, and the judgments that rehabilitation physicians and their teams make when treating patients. The cherry-picking of single references embedded in voluminous patient files does not consider the totality of the clinical circumstances of each patient and results in inconsistent and skewed error rates.
- **Lack of appropriate physician deference:** In 2010, CMS published a new set of IRF medical necessity and documentation standards still in use today, explicitly stating in the final rule, "[W]e are placing more weight on the rehabilitation physician's decision to admit the patient to the IRF . . . ."[19] Auditors that fail to apply this standard undermine the decisions of rehabilitation physicians and often oversimplify the conditions, symptoms, and complications of patients treated in IRFs.
- **Lack of practical knowledge by contract reviewers**: Auditors often lack knowledge of the practical delivery of IRF care that does not obviously translate to paper or electronic medical records. For example, reviewers may lack knowledge of how an electronic medical record ("EMR") functions in practice. Some of the cases discussed in the course of this audit involved EMR functionality limitations that contributed to the identification of alleged "errors" where the Stakeholders disagreed. Contractors should be educated on industry-standard EMR systems so they can accurately evaluate IRF medical records.
- **Incongruity of purpose of medical records**: Medical records serve two distinct purposes in the Medicare program—(1) to facilitate treatment, allowing the rehabilitation physician to communicate with the rehabilitation team in real time to treat the patient during the inpatient stay, react to complications, and alter treatment plans as necessary, and (2) to document regulatory compliance to secure payment from Medicare. The use of templates in EMRs helps drive clinical best practices and facilitates regulatory compliance. Such templates are guides for staff, but they tend to be viewed negatively in an audit framework. For example, auditors concluded that the use of templates showed a lack of "individualization" of care plans as required by 42 C.F.R. § 412.622(a)(5), despite the template responses being unique to each patient. Auditors also questioned directives in the patient file that do not describe alternative treatments that may have been considered and rejected. While evidence of such medical decision-making may be useful to an auditor, it is often irrelevant to treating the patient and is extraordinarily burdensome on rehabilitation physicians and other members of the rehabilitation team to record such information in each patient file.

VI. IRF Stakeholder Response to OIG Recommendations

OIG offers four recommendations to clarify IRF documentation, coverage, and billing requirements under Medicare. The Stakeholders generally agree with these recommendations and offer specific comments immediately below each recommendation.

Recommendation No. 1: OIG recommends that "CMS revise or clarify IRF documentation requirements related to the: (1) development and individualization of the plan of care, (2) leadership of interdisciplinary team ("IDT") meetings by rehabilitation physicians, (3) review at IDT meetings

[19] *See* 74 Fed. Reg. 39,762; 39,791 (Aug. 7, 2009).

of enrollee progress toward rehabilitation goals and identification of any problems that could impede such progress, and (4) functional status of enrollees during the preadmission screening."[20]

The Stakeholders agree that clarity may be helpful to standardize expectations of the level and type of documentation that fulfill the regulatory requirements related to these specific recommendations. However, we firmly believe that requiring IRFs to comply with additional and more detailed regulations is not the answer to resolving these problems. Any changes to the regulations should be grounded in greater deference to the rehabilitation physician's role in decision-making, eliminating burdensome regulations whenever possible, and simple clarifications to eliminate ambiguity. In 2010, CMS revised the IRF regulations with detailed specifications to avoid the subjective judgments of Medicare contractors and to lessen the number of claim denials under prior guidance. Unfortunately, more regulation did not lead to lower error rates or better auditing because auditors interpreted these requirements narrowly without appropriate deference to the rehabilitation physicians.

To facilitate clarity and eliminate unnecessary findings of error in future IRF claim reviews, the Stakeholders recommend that CMS, in collaboration with IRF stakeholders, identify, develop, and disseminate "best documentation practices" through General Compliance Program Guidance (developed in collaboration with CMS and OIG) or additional guidance through the Medicare Benefit Policy Manual. Such guidance would better guide IRFs and government auditors on documentation that fulfills the requirements of the regulation that:

- The rehabilitation physician "developed" the plan of care by clarifying that when a rehabilitation physician concurs with and signs the individualized overall plan of care, the rehabilitation physician should be presumed to have developed the individualized overall plan of care.[21]
- The rehabilitation physician "led" the team meeting by clarifying that when a rehabilitation physician is present or participated virtually in the team meeting and notes indicate the physician's (1) involvement in reviewing treatment plans of team members and (2) signed concurrence with the conclusions of the team meeting, the rehabilitation physician should be presumed to have led the meeting.
- Progress toward rehabilitation goals, any problems that could impede such progress, and the functional status of enrollees during the preadmission screening be appropriately documented. These are topics that should be further explored in good faith by CMS and the IRF field to develop best practices.

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[20] OIG Report at 22.

[21] In two appeals recently decided by the Medicare Appeals Council, and consistent with CMS's determination in this audit report, Administrative Law Judges found that, based on the regulatory requirements that a rehabilitation physician document his or her review and concurrence with the preadmission screening (42 C.F.R. § 412.622(a)(4)(i)), combined with the regulatory requirement that all medical record entries (including all of the documentation required under the IRF coverage regulations) be dated, timed, and *authenticated*, in written or electronic form, by the person responsible for providing or evaluating the service provided (42 C.F.R. § 482.24(c)(1)), *the physician's signature on the preadmission screening was sufficient, standing alone, to satisfy the requirements of the regulation*. Madonna Rehabilitation Hosp., DAB No. M-23-3544, at 3-4 (2026); Madonna Rehabilitation Hosp., DAB No. M-23-3545, at 3 (2026). This standard should be equally applicable to the physician's documentation of his or her involvement in developing the individualized overall plan of care and leading the interdisciplinary team meetings.

Further, CMS should instruct its contractors that, absent indications of fraud, they should not deem claims to be in error if these best documentation practices are met. Both IRFs and government contractors should commit to initial and ongoing training and education on these best practices.

Recommendation No. 2: OIG recommends that "CMS revise or clarify IRF coverage requirements to define: (1) what constitutes a reasonable expectation that an enrollee requires supervision by a rehabilitation physician, (2) what it means to have active and ongoing therapeutic intervention from multiple disciplines, and (3) what it means to be sufficiently stable to actively participate in an intensive rehabilitation therapy program."

The Stakeholders agree that clarity from CMS through a best practices model as outlined in Recommendation No. 1 may be helpful to align expectations between OIG, CMS, and IRFs. However, we restate that compliance with additional and more detailed regulations is not the answer. These three areas are at the heart of what the rehabilitation physician contributes to an IRF course of treatment. CMS should primarily grant greater deference to the rehabilitation physician when assessing compliance with these regulatory requirements. Further, we recommend that:

- CMS reeducate and train contractors to ensure that they apply the appropriate standard for determining compliance with the coverage criteria listed in 42 C.F.R. § 412.622(a)(3), which relies on a reasonable expectation that the patient meets the relevant criteria *at the time of admission*, not a review of records after discharge.
- CMS clarify that medical necessity of IRF admissions must be determined based on the totality of the clinical circumstances documented throughout the entire medical record.
- CMS educate its contractors that they should apply the guidance from the preamble of the 2010 IRF regulation, 74 Fed. Reg. at 39791, that "more weight" be given to the rehabilitation physician's judgment at the time of the IRF admission decision and throughout the course of IRF treatment.

Recommendation No. 3: OIG recommends that "CMS revise or clarify IRF-PAI signature requirements." We agree with this recommendation. We also recommend that CMS modify and remove regulations related to IRF-PAI deadlines so they are consistent with current payment and quality reporting standards, which include timelines related to the completion of the admission assessment, the discharge assessment, and clarification of "encoding" timeline requirements.

Recommendation No. 4: OIG recommends that "CMS offer training and learning sessions to assist IRFs with regulation compliance." While we support opportunities for additional training and education on CMS requirements, we restate that CMS and the Stakeholders were in agreement on whether Medicare requirements were met in the majority of case examples we discussed. If CMS agrees to enter into discussions with the IRF field on best practices or otherwise issues clarifications designed to reduce the error rate, such additional education could be very useful. However, we believe that additional educational opportunities are necessary for contractors that audit IRFs as well. This would include, for example, a training program focused on the wholistic application of IRF regulations when assessing records (as described in Recommendation No. 1 above) to improve both IRF program integrity and the accuracy of IRF audits, and appropriate reviewer standards for any individuals involved in IRF audits.

We also recommend that CMS implement a standard for audit contractor expertise under traditional Medicare similar to that incorporated into the Medicare Advantage program, which requires that reviewers have "expertise in the field of medicine or health care that is appropriate for

the services at issue, including knowledge of Medicare coverage criteria."[22] This should include relevant and ongoing training and education to ensure that reviewers understand the specific coverage criteria for IRF admissions in the Medicare benefit, including knowledge of current evidence-based standards and clinical guidelines. Although IRF stakeholders have serious concerns with Medicare Advantage plans' abuse of prior authorization and other utilization management techniques, these specific regulations would be helpful if applied to traditional Medicare and universally applied by Medicare Advantage plans.

VII. Additional Recommendations by the IRF Stakeholders

The Stakeholders offer the following additional recommendations for CMS's consideration, which we developed from our review of the sampled cases and our two-day meeting with OIG and CMS. These recommendations are critical for auditors to improve the accuracy and reliability of IRF audits and better understand the care provided in IRFs. We recommend that:

- CMS require that a physician with specialized training and experience in inpatient rehabilitation be a part of any review that denies IRF claims on the basis of medical necessity. This is the same regulatory standard that CMS applies to rehabilitation physicians[23] practicing in IRFs and, therefore, the level of training and expertise between the rehabilitation physician and the claim reviewer would be equivalent.[24]
- CMS limit payment denials to non-compliance with regulatory requirements that have a direct impact on patient care. Non-compliance with technical requirements that do not impact the payment level and do not impact the medical need for IRF services should not be considered overpayments, nor should they be included in the extrapolation of overpayment amounts.
- CMS should establish a "*de minimis*" threshold under which IRFs are not penalized for minor documentation errors or omissions when the totality of the care provided clearly establishes coverage and overall compliance with regulatory requirements.

VIII. Conclusion

AAPM&R, AMRPA, and FAH thank OIG for the opportunity to engage with the agency throughout this audit. Our recommendations in this response to the draft OIG report offer practical solutions to resolve the ambiguities identified by OIG to reduce errors while clarifying Medicare documentation, coverage, and billing standards. We welcome the opportunity to continue to collaborate with OIG and CMS to further our mutual goal of ensuring the delivery of high-quality care to Medicare beneficiaries in need of inpatient hospital rehabilitation.

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[22] 42 C.F.R. § 422.566(d).
[23] *See* 42 C.F.R. § 412.622(c).
[24] This is the same standard adopted by the IRF Review Choice Demonstration ("RCD") currently in effect in Alabama and Pennsylvania, which has shown recent "affirmation rates" of pre-claim IRF admissions at 95% and above.

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