A PUBLICATION OF THE HEALTH CARE COMPLIANCE ASSOCIATION

COMPLIANCE TODAY

MAGAZINE

JANUARY 2019

GREG RADINSKY
SENIOR VICE PRESIDENT &
CHIEF CORPORATE COMPLIANCE OFFICER
NORTHWELL HEALTH

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(P12)

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NEW CMS RULE REVISIONS AFFECTING YOUR INPATIENT REHABILITATION FACILITY

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An inpatient rehabilitation facility (IRF) must meet specific coverage criteria for care to be considered reasonable and necessary. Failure to meet the IRF coverage criteria may result in denial of a claim. Because the IRF coverage criteria had not been updated since January 1, 2010, the Centers for Medicare & Medicaid Services (CMS) realized that changes were needed to maximize the quality of care provided to IRF patients. Therefore, beginning fiscal year 2019 (for all IRF discharges on or after October 1, 2018), CMS implemented revisions to the IRF coverage criteria in an effort to "allow providers and physicians to focus the majority of their time treating patients rather than completing paperwork."

These revisions were published on August 6, 2018, as part of CMS's IRF Prospective Payment System final rule (IRF final rule). The changes were aimed at alleviating the administrative burden placed on IRFs. This article will outline the revisions to the IRF final rule regarding coverage requirements and will provide recommendations to help you ensure compliance at your IRF.

Physician supervision

IRF coverage criteria require that at the time of the patient's admission to the IRF, there must be a reasonable expectation that the patient "requires physician supervision by a rehabilitation physician." To satisfy this requirement, the rehabilitation physician must conduct at least three face-to-face visits with the patient per week throughout the patient's stay in the IRF.[1] These face-to-face visits must be documented in the patient's medical record.[6]

The purpose of the physician supervision requirement is "to ensure that the patient's medical and functional statuses are being

continuously monitored as the patient's overall plan of care is being carried out."[2] CMS believes that the physician supervision requirement's purpose is different from that of the post-admission physician evaluation (PAPE), which must be completed by a rehabilitation physician within 24 hours of the patient's admission to the IRF and be retained in the patient's medical record.[1] The purpose of the PAPE "is to document (in the IRF medical record) the patient's status on admission, identify any relevant changes that may have occurred since the preadmission screening, and provide the rehabilitation physician with the necessary information to begin development of the patient's overall plan of care."[2]

CMS has reiterated its belief that the physician supervision requirement and the PAPE are two different types of assessments; however, in the IRF final rule, CMS modified the physician supervision requirement to allow the PAPE to count as one of the face-to-face physician visits. [7] This revision will allow the rehabilitation physician "the flexibility to assess the patient and conduct the post-admission physician evaluation during one of the three face-to-face physician visits required in the first week of the IRF admission."[2] It should be noted that this revision is not meant to limit rehabilitation physicians from seeing patients more than three times in the first week of the patient's IRF stay.[7]

CMS expects "that each rehabilitation physician will exercise his or her best clinical judgement to determine the need and frequency of rehabilitation physician visits for a given patient." Interestingly, CMS estimates that only about half of IRFs will actually adopt this new policy, because many rehabilitation physicians visit patients more than the minimum three times per week.[7]

Recommendation: Provide education to the providers at your facility to ensure that they understand the requirements for PAPEs and physician supervision, including the importance of adequate documentation in the medical record. Physicians must remember that the PAPE requirement remains unchanged; however, by adequately completing and documenting the PAPE, a physician is only required to have two additional face-to-face visits with the patient in the first week of the patient's admission to the IRF.[7]

Interdisciplinary team meetings

Another IRF coverage requirement is that the patient's care must be managed by an interdisciplinary team, which includes weekly team meetings that satisfy the requirements specified in the regulation. The requirements state that "team meetings must be led by a rehabilitation physician and that the results and findings of the team meetings, and the concurrence by the rehabilitation physician with those results and findings, are retained in the patient's medical record."[7]

CMS understands that a rehabilitation physician might not be able to attend all the team meetings in person; therefore, CMS has previously instructed physicians that the rehabilitation physician may attend the team meetings by telephone "as long as it is clearly demonstrated in the documentation of the IRF medical record that the meeting was led by the rehabilitation physician."[8]

In the IRF final rule, CMS revised this requirement to include the option for the rehabilitation physician to lead the team meetings "remotely via another mode of communication, such as video or telephone conferencing." [1,9]

Additionally, in the IRF final rule, CMS explicitly states that it is finalizing this rule without any additional documentation requirements, because it does not "feel that documentation of the rehabilitation physician's physical location during the team meeting in the IRF medical record is needed to ensure that the rehabilitation physician is making the decisions."

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CMS anticipates that this revision "will allow time management flexibility and convenience for all rehabilitation physicians, especially those located in rural areas who may need to travel greater distances between facilities." In the future, CMS may allow other team meeting attendees to participate remotely; however, for the time being this new revision only applies to the rehabilitation physician.[8]

By implementing this revision, CMS has given IRFs the flexibility to: (1) adopt the new rule and allow

the rehabilitation physician to participate in the team meetings remotely; (2) maintain a protocol that the rehabilitation physician must lead the team meetings in person; or (3) allow the rehabilitation physician to participate in the team meetings remotely during certain situations, such as only allowing remote participation during extenuating circumstances.[8]

CMS maintains the belief that the majority of the IRF visits should be face to face to maximize the quality of care provided to a patient...

Recommendation: Work with the leadership at your IRF to decide whether rehabilitation physicians will be permitted to participate remotely when conducting the team meetings and, if so, under what conditions. Based on your IRF needs, you may have a preference for one approach over another. For instance, your IRF may have a very high functioning, in person, team meeting protocol already in place that you do not want to disrupt. If that is the case, it may be best for your IRF to establish a policy that requires the rehabilitation physicians to be physically present for the team meetings.

Admission order documentation

In the IRF final rule, CMS removed the requirement that at the time of patient admission "the inpatient rehabilitation facility must have physician orders for the patient's care during the time the patient is hospitalized."[10] The purpose behind removing this requirement was to reduce regulatory redundancy and administrative burden, because the requirement for an admission order continues to be addressed through hospital Conditions of Participation and hospital admission order payment requirements.[11] For instance, CMS considers an individual to be a hospital inpatient if the patient is formally admitted under an order for inpatient admission by a physician or other qualified practitioner.[9] Qualified practitioners (other than physicians) may be permitted to order the inpatient admission, if they are allowed to do so under "State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules and regulations."[12]

In addition to removing duplication in the IRF coverage criteria, CMS also implemented a change under the Hospital Inpatient Prospective Payment Systems final rule. CMS removed the requirement that as a *condition of payment*, the "physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services." CMS will consider this requirement satisfied if "other available documentation, such as the physician certification statement when required, progress notes, or the medical record as a whole, supports that all the coverage criteria (including medical necessity) are met, and the hospital is operating in accordance with the hospital conditions of participation."[13]

To be clear, this change does not alter the requirement that "a beneficiary becomes an inpatient when formally admitted as an inpatient under an order for inpatient admission (nor that the documentation must still otherwise meet medical necessity and coverage criteria)." It only revises the prior documentation requirement that inpatient orders must be present in the medical record as a condition of payment.[14]

Recommendation: Continue to ensure that inpatient orders are entered in accordance with CMS regulations. "The physician order remains a significant requirement because it reflects a determination by the ordering physician or other qualified practitioner that hospital inpatient services are medically necessary, and initiates the process for inpatient admission."[13]

Potential future changes

CMS is considering whether rehabilitation physicians should have the flexibility to conduct some IRF patient visits remotely via other modes of communication, such as video or telephone conferencing.[11] As discussed earlier in this article, the current IRF physician supervision requirement necessitates that the rehabilitation physician conduct at least three face-to-face visits with the patient per week throughout the patient's stay in the IRF.[1] In 2010, when the IRF coverage criteria were initially implemented, CMS included this face-to-face requirement "to ensure that the patient receives the most comprehensive in person care by a rehabilitation physician throughout the IRF stay." CMS maintains the belief that the majority of the IRF visits should be face to face to maximize the quality of care provided to a patient; however, given the advent and quality of alternative methods of communication, CMS is considering giving rehabilitation physicians more flexibility in

conducting patient visits. CMS is not ready to implement changes to the three face-to-face requirements at this time, but may do so in the near future.[11]

CMS is also contemplating whether the current IRF requirements should be modified to allow non-physician practitioners (e.g., physician assistants and nurse practitioners) to play a greater part in the IRF care, thus removing some of the burdens placed on rehabilitation physicians (e.g., face-to-face visits and accompanying documentation). CMS has not yet modified these requirements due to concerns regarding whether non-physician practitioners have the specialized training required to handle these responsibilities. CMS also has concerns that implementing any changes to these requirements may impact patients' ability "to receive the hospital level and quality of care that is necessary to treat such complex conditions." CMS will continue to contemplate this potential refinement to current IRF coverage criteria and may make changes in the future.[11]

Conclusion

CMS has made an effort to alleviate the regulatory burden placed on IRFs, in part, by making changes to IRF coverage criteria. Interestingly, many of the changes that CMS implemented are optional. For instance, the rehabilitation physician may conduct the interdisciplinary team meetings remotely, but he/she is not required to do so.[8] Similarly, although the PAPE may count as one of the three face-to-face requirements, the rehabilitation physician has the flexibility to visit the patient more than three times in the patient's first week of IRF admission.[2]

Each IRF should evaluate the changed criteria, decide how they would like to address the changes, and establish processes to implement those changes, if any. Once this has been done, the IRF should ensure that it provides its personnel with the appropriate training. Remember that even though CMS has loosened a few of the previous IRF requirements, the majority of them remain the same and must be followed. CT

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Endnotes

1. 42 CFR 412.622 (Basis of payment). https://bit.ly/2Nv9rFH
2. 83 Fed. Reg. 38514, 38550 (Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2019) August 6, 2018. https://bit.ly/2A7HBta.
3. 83 Fed. Reg. 38514, 38549.
4. 83 Fed. Reg. 38514, 38514.
5. Centers for Medicare and Medicaid Services, *Medicare Benefit Policy Manual*, CMS Pub. 100-02, Chap. 1, Sec. 110 (Rev. 234, March 10, 2017). https://go.cms.gov/2TubP2r
6. Danielle C. Gordet, "Rehabbing critical documentation processes in your inpatient rehabilitation facility," *Compliance Today*, September 2018, Volume 20, Issue 9, p. 77.
7. 83 Fed. Reg. 38514, 38551.
8. 83 Fed. Reg. 38514, 38552.
9. 83 Fed. Reg. 38514, 38553.
10. 42 CFR 412.606 (Patient assessments). https://bit.ly/2BlQkd8
11. 83 Fed. Reg. 38514, 38554.
12. 42 CFR 482.24 (Condition of Participation: Medical Record Services). https://bit.ly/2KjUk0J
13. 83 Fed. Reg. 41144, 41507 (Hospital Inpatient Prospective Payment Systems for Federal Fiscal Year 2019), August 17, 2018. https://bit.ly/2QcjrrE
14. 83 Fed. Reg. 41144, 41510.

- The post-admission physician evaluation may count as one of the three face-to-face physician visits in the first week of a patient's inpatient rehabilitation facility (IRF) admission.
- The rehabilitation physician may now lead the interdisciplinary team meetings remotely via video or telephone conferencing.
- CMS removed the IRF admission order documentation requirement; however, to be considered an inpatient, a patient is still required to be formally admitted as an inpatient under an order for inpatient admission.
- CMS is considering future policy changes that would give rehabilitation physicians the flexibility to conduct some IRF patient visits remotely.
- In the future, CMS may allow non-physician practitioners to play a greater role in IRF care, thereby removing some of the requirements placed on rehabilitation physicians.