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an interview with
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Rehabbing critical documentation processes in your inpatient rehabilitation facility

» Inpatient rehabilitation facilities are required to complete four distinct medical record components for the services to be considered reasonable and necessary.

» The rehabilitation physician has specific obligations during the preadmission screening process, which must occur prior to the patient's admission.

» A post-admission physician evaluation must be completed within 24 hours of a patient's admission.

» The rehabilitation physician must develop an individualized overall plan of care and document it in the medical record.

» Interdisciplinary team meeting documentation must include evidence that certain discussion elements were satisfied.

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It is imperative to ensure that your inpatient rehabilitation facility (IRF) is meeting the Center for Medicare & Medicaid Services' (CMS) requirements. This article will walk you through the requirements and discuss certain tips to keep in mind as you work with your hospital partners to ensure they understand how to maintain compliance. (See Table 1 on page 81 for a quick summary of the required documentation.)

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Importance of documentation

All healthcare compliance professionals know that documentation matters. This message is ingrained in us from the beginning of our careers. It is therefore no surprise that the Office of Inspector General (OIG) *Supplemental Compliance Program Guidance for Hospitals* states: "It is axiomatic that all claims and requests for reimbursement from the Federal health care programs—and all documentation supporting such claims or requests—must be complete and accurate..."[1]

The OIG's continued emphasis on the importance of documentation is highlighted when it comes to IRFs, which must meet specific documentation requirements for care to be considered reasonable and necessary. For instance, the *Medicare Benefit Policy Manual* instructs all Part A and Part B Medicare Administrative Contractors (MACs) conducting IRF reviews to "consider the documentation contained in a patient's IRF medical record when determining whether an IRF admission was reasonable and necessary;" in particular, evidence related to the preadmission screening, the post-admission physician evaluation, and the overall plan of care.[2]

The OIG signaled increased scrutiny in the area of IRF documentation by including a Fiscal Year (FY) 2016 active Work Plan Item to review whether IRFs nationwide billed claims in compliance with Medicare documentation and coverage requirements.[3] The Work Plan Item is expected to be issued in FY 2018. While we wait for the results, the OIG continues to

release compliance reviews of IRFs that have failed to satisfy documentation requirements. In one recent review, the OIG found the hospital billed 20% of the audited IRF claims incorrectly, because they did not comply with Medicare documentation requirements.[4]

As will be discussed in greater detail below, CMS requires that the services for each patient for which the IRF seeks payment be reasonable and necessary. In order for these services to be considered reasonable and necessary, the patient's medical record at the IRF must contain the following four elements.[5]

1. Comprehensive preadmission screening

The preadmission screening is of the utmost importance, because this document paints the picture of the patient's status before he/she was admitted to the IRF and the reasons that led the IRF clinicians to determine that the admission was reasonable and necessary.[2] Documentation of the preadmission screening must be retained in the patient's medical record and must include[6]:

- the patient's prior level of function (prior to the event causing the need for intensive rehabilitation therapy),
- the expected level of improvement,
- the expected length of time to achieve the level of improvement,
- an evaluation of the risk for clinical complications,
- the conditions that caused the need for rehabilitation,
- the therapies needed,
- the expected frequency and duration of IRF treatment,
- the anticipated discharge destination, and
- any anticipated post-discharge treatments.

Although a physician extender may complete the preadmission screening, a rehabilitation physician (defined as "a licensed physician with specialized training and experience in inpatient rehabilitation"[7]) is required to review and document his/her concurrence with the findings and results of the preadmission screening *prior* to the patient's admission to the IRF.

The preadmission screening must typically be conducted within the 48 hours immediately preceding a patient's admission to an IRF; however, if all of the required preadmission screening elements were included in a screening that occurred more than 48 hours before admission, CMS permits such screenings so long as an update occurs in person or by phone "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."[5]

CMS gives IRFs the freedom to decide how they will ensure that all of the preadmission screening elements are included in the patient's medical record. MACs are told to focus on ensuring that the screenings are complete, accurate, and support the appropriateness of the IRF admission—and not to critique how the process that was used to make those determinations was organized.[2]

When reviewing whether your IRF has a strong process in place, keep in mind that CMS does not believe "check-off lists" are an acceptable form of documenting the preadmission screening.[8] Accordingly, merely having a form with yes/no checkboxes for the various elements of the preadmission screening is not appropriate without an accompanying narrative explanation.[9]

In addition, it is important to ensure that each preadmission screening captures the rehabilitation physician's signature (concurring with the findings of the screening), as well as the date and time of his or her signature.[6] "A dated and timed signature by the rehabilitation physician with one sentence saying that he or she has reviewed and concurs with the findings and results of the preadmission

screening is acceptable."[9] The OIG has denied IRF documentation of preadmission screenings when the claims lacked signatures, dates, and/or times when the screenings were performed or approved, because—lacking these—the OIG was unable to determine whether the screenings or screening reviews were performed within the 48 hours immediately preceding admission.[6]

2. Post-admission physician evaluation (PAPE)

A PAPE 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.[5] PAPE documentation must (1) describe the patient's status on admission to the IRF; (2) serve as a comparison with the information noted in the preadmission screening; (3) form the basis for the patient's overall individualized plan of care; [5] (4) identify any relevant changes that have occurred since the preadmission screening; (5) include a documented history and physical exam, as well as a review of the patient's prior and current medical and functional conditions and comorbidities; and (6) support the medical necessity of the IRF admission.[6]

It is important to note that although CMS has said that a resident or physician extender may complete the history and physical exam, the rehabilitation physician must visit the patient and complete the other PAPE requirements.[8] If, while completing the PAPE, the rehabilitation physician determines that the patient's needs no longer support IRF admission, the IRF must immediately begin the process of discharging the patient to the appropriate level of care.[2]

An IRF claim may be denied if even one part of the required information is missing from the PAPE documentation. For instance, OIG audits have denied claims for insufficient documentation when the rehabilitation physician completed the history and physical examination within 24 hours of admission, but failed to include "additional required information, such as a comparison with the information noted in the preadmission screening documentation and an identification of any relevant changes that may have occurred since the preadmission screening." Additionally, it is important to ensure that the history and physical examination documentation includes the date and time it occurred. CMS has denied claims when the history and physical examinations are documented but fail to include evidence that they were conducted within 24 hours of admission.[6]

3. Individualized overall plan of care (OPoC)

The rehabilitation physician, with input from the interdisciplinary team (described later in this article), is required to develop the OPoC within four days of the patient's admission to the IRF.[5] The rehabilitation physician is responsible for integrating the information from the patient's preadmission screening, the PAPE, and other therapy assessments into the OPoC and documenting the OPoC in the patient's medical record.[2]

The OPoC can be an extension of the preadmission screening and the PAPE—it does not have to repeat all of the information that they contained. The rehabilitation physician is ultimately responsible for the admission decision to the IRF, but physician extenders may work in collaboration with the rehabilitation physician in developing the OPoC for the physician's approval and signature.[9]

The OPoC must detail (1) functional outcomes; (2) discharge destination from the IRF; and (3) the patient's medical prognosis and anticipated interventions (i.e., physical, occupational, speech-language pathology, and prosthetic/orthotic therapies) required during the IRF stay, including expected (a) intensity (number of hours per day), (b) frequency (number of days per week),

and (c) duration (total number of days during the IRF stay).[2]

As with the other IRF requirements, CMS has given IRFs the leeway to develop their own processes to ensure that all the required elements are met.[2] It is important to note that the OIG has denied IRF claims where IRF personnel prepared and documented assessments within four days of the IRF admission, but the "rehabilitation physicians did not develop and integrate this information into individualized overall plans of care and document them in the medical records."[6]

Implementation of an interdisciplinary team approach

IRFs are required to have an interdisciplinary team approach to treating patients. Documentation in the patient's medical record must demonstrate that weekly interdisciplinary team meetings occurred and consisted of the following team members, all of which must have current knowledge of the patient's medical and functional status: (1) rehabilitation physician, (2) registered nurse with specialized training or experience in rehabilitation, (3) a social worker or case manager (or both), and (4) a licensed or certified therapist from each therapy discipline involved in treating the patient.[5] CMS expects that all treating professionals from the required disciplines will be at every meeting or, in the case of an absence, send a designee of the same discipline in their stead who has knowledge of the patient.[2]

The rehabilitation physician is responsible for leading the weekly meetings, the purpose of which are "to implement appropriate treatment services; review the patient's progress toward stated rehabilitation goals; identify any problems that could impede progress towards those goals; and, where necessary, reassess previously established goals in light of impediments; revise the treatment plan in light of new goals; and monitor continued progress toward those goals."[5]

MACs are instructed to review documentation of the interdisciplinary team meetings to ensure that the following information is also included in the medical record: (1) the names and professional designations of the participants in the team conference; (2) the occurrence of the meeting; (3) decisions made during the meeting (e.g., decisions regarding discharge planning and the need for adjusting treatment goals); and (4) concurrence by the rehabilitation physician with the meeting's results and findings.[2]

Like the previous requirements, the OIG is less concerned about hospital processes as long as the medical record documentation includes sufficient information to support the occurrence of the team meetings and evidence that discussion of the required elements occurred. The OIG has denied claims where the "rehabilitation physicians made only brief mention of team meetings in certain progress notes, which describe the daily status of the patients, and did not address additional requirements."[6]

Takeaways

Now is the time to take a good look at the IRF you work with to ensure that it is meeting the discussed CMS regulations. There are numerous documentation requirements, so make sure that you have a strong team in place to ensure compliance. Build a team that spans the hospital disciplines, gaining buy-in from all stakeholders involved, including IRF staff, Internal Audit, Information Technology, and hospital executives. By establishing a robust, multidisciplinary team to monitor and facilitate the documentation of all the requirements previously described, you will establish your best chance of remaining compliant with the varying rules and regulations and reduce claim denial rates.

Table 1: Documentation Requirements for Inpatient Rehabilitation Facilities

Elements	Documentation Must Include	Who Is Involved?	Timing	Tips
Preadmission Screening	• Patient's prior level of function • Expected level of improvement • Expected length of time to achieve level of improvement • Evaluation of risk for clinical complications • Conditions that caused need for rehabilitation • Therapies needed • Expected frequency and duration of IRF treatment • Anticipated discharge destination and post-discharge treatments	Physician Extender ***may*** complete it Rehab Physician ***must*** review and document concurrence with findings and results	Within 48 hours immediately preceding admission	Check Off Lists are not an appropriate way to document the screening's elements Screening must include date and time it occurred, as well as Rehab Physician signature
Post-Admission Physician Evaluation ("PAPE")	• Description of patient's status on admission to IRF • A comparison with information noted in preadmission screening • A basis for patient's OPoC • Identification of any relevant changes since preadmission screening • Documented history and physical exam, and a review of patient's prior and current medical and functional conditions and comorbidities • Support for medical necessity of IRF admission	Resident or Physician Extender ***may*** complete history and physical exam Rehab Physician ***must*** visit patient and complete the other PAPE requirements	Within 24 hours of admission to IRF	History and physical exam documentation must include the date and time it occurred
Individualized Overall Plan of Care ("OPoC")	• Patient's medical prognosis and anticipated interventions required during IRF stay, including expected: » Intensity (number of hours per day), » Frequency (number of days per week), and » Duration (total number of days during the IRF stay) • Functional outcomes • Discharge destination from IRF	Physician Extender ***may*** work with Rehab Physician in developing OPoC for Rehab Physician approval and signature Rehab Physician ***must*** approve and sign OPoC	Within 4 days of admission to IRF	Rehab Physician may write out the OPoC or bring together individual plans of care from different treating disciplines and modify or add to them, as appropriate
Interdisciplinary Team Approach to Care	• Evidence that meetings occurred weekly • Names and professional designations of team participants • Decisions made during meetings, including discussion of: » Appropriate treatment services; » Patient progress toward stated rehab goals; » Identification of problems that could impede progress towards goals; and, » Where necessary, reassessment of previously established goals in light of impediments, revision of treatment plan in light of new goals, and monitoring of continued progress toward those goals • Evidence of concurrence by Rehab Physician with meeting results and findings	Must consist of the following members, who must have current knowledge of patient's medical and functional status: • Rehab Physician with specialized training and experience in rehab • Registered Nurse with specialized training or experience in rehab • Social Worker or Case Manager (or both) • Licensed or Certified Therapist from each therapy discipline involved in treating patient	Weekly during IRF stay	Medical Record documentation must include sufficient information to support occurrence of meetings and evidence that discussion of required elements occurred

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