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Rehabbing critical documentation processes in your inpatient rehabilitation facility

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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 for a quick summary of the required documentation.)

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. 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 priorto 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."[8]

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.[9]

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.[10] 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.[11]

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.[12] "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."[13] 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.[14]