

## REFERENCES

1. <http://www.cdc.gov/injury/wisqars/>.
2. Finkelstein EA, Corso PS, Miller TR. *The Incidence and Economic Burden of Injuries in the United States*. USA: Oxford University Press; 2006.
3. Hansen TS, Engberg AW, Larsen K. Functional oral intake and time to reach unrestricted dieting for patients with traumatic brain injury. *Arch Phys Med Rehabil* 2008;89:1556-62.
4. Shalev AY, Freedman S, et al. Prospective study of posttraumatic stress disorder and depression following trauma. *Am J Psychiatry* 1998;155:630-7.
5. Gregg SC, Harrington DT, Adams CA Jr. The evolution of the Rhode Island trauma system: where do we stand? *Med Health RI* 2009 May;92:172-4.

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# Inpatient Rehabilitation Services: Regulatory Changes

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Inpatient rehabilitation facilities (IRFs) operate in a changing environment. First was the transition from the reimbursement system of the 1980s and 1990s to our current Prospective Payment System. Along with that came the challenges of educating and re-educating staff and patients about achieving optimal outcomes within prescribed periods of time. Now the paradigm is shifting once again. This time the shift is more clinical rather than fiscal. Although the following discussion specifically applies to patients with Medicare coverage, the new guidelines set the standard within the industry for all patients.

In 2009, the Centers for Medicare and Medicaid Services (CMS) rescinded HCFA Ruling 85-2, "Medicare Criteria for Coverage of Inpatient Hospital Rehabilitation Services," 50 FR 31040 (July 31, 1985) as corrected at 50 FR 32643 (August 13, 1985). Some regulations remain unchanged. Patients can be considered acute rehabilitation candidates if they can be expected to make significant functional gains in a reasonable time.

They must require intensive and interdisciplinary care from rehabilitation clinicians, including twenty-four-hour rehabilitation nursing and either physical or occupational therapy along with speech therapy. Patients should have the potential to return to the community, not a skilled nursing facility (SNF). Medical management, typically by a primary care doctor, is required, as well as close supervision by a rehabilitation physician. Inpatient rehabilitation should be reasonable and necessary, with the patient's needs unable to be met at a SNF or outpatient facility. The 60% Rule for IRFs, which determines the DRG-exempt status of the unit or facility, is based on 60% of patients falling within one of 13 diagnostic categories (CMS-13). Ischemic or hemorrhagic strokes, late effects of stroke, hypertensive encephalopathy, and diseases of cerebral arteries and venous sinuses, e.g. amyloid, are eligible diagnoses. Brain injuries may include benign and malignant neoplasm, meningitis, encephalitis (and its late effects), toxic encephalopathy, traumatic injuries/concus-

sions; complications of medical and surgical conditions (encephalopathies) are also considered qualifying diagnoses. Among various qualifying neurologic conditions are neuropathies (e.g. B12, GBS), mononeuritis multiplex, radiculopathies, plexopathies, and myopathies. Patients with complications related to worsening of Parkinson's, multiple sclerosis, muscular dystrophies, motor neuron diseases, and post-polio syndrome can also be considered. Spinal cord injuries, either traumatic or those related to myelitis, neoplasms, or infections still qualify for acute rehabilitation, as do hip fractures at the neck and/or head of the femur, the acetabulum, or in the subtrochanteric area. Amputations may be vascular, traumatic, or due to infections, but residual limb complications are also included in the CMS-13. Joint replacements may qualify, but only if they are bilateral, or if the patient with a single replacement is morbidly obese (BMI  $\geq 50$ ) or if the age is  $\geq 85$ . Major multiple trauma is an important category that obviously requires intensive rehabilitation, as are major burns.

On occasion, patients with arthritic conditions may benefit from inpatient rehabilitation, but only if their functional status has declined and they have not benefited from outpatient therapy. These include polyarticular rheumatoid arthritis, psoriatic arthritis, seronegative arthropathies, and systemic vasculitides with joint inflammation. Osteoarthritis at two or more major weight-bearing joints (e.g. elbow, shoulder, hip, knee) is another qualifying condition.

A co-morbidity from the 13 diagnostic categories *and* a significant decline in function, e.g. a de-conditioned patient with pneumonia who has a stroke, is also acceptable for inpatient rehabilitation.

More changes to the Medicare Benefit Policy were issued on October 23, 2009 for IRF admissions and discharges on or after January 1, 2010 that focus on establishing a patient's clinical ability to meet criteria for the medical necessity of inpatient rehabilitation. CMS states that only the rehabilitation physician is qualified to decide if the patient meets criteria for medical necessity and is stable enough for three hours of therapies per day. As a result, one cannot establish medical necessity by using diagnostic screens such as the CMS-13 categories mentioned above. A comprehensive pre-screening process must be completed and documented within 48 hours of the admission. A licensed or certified clinician, such as a nurse or therapist, who is designated by the rehabilitation physician, may collect the information for the Pre-Screening Evaluation. Then the rehabilitation physician must revise that evaluation to determine if the patient meets the threshold of medical necessity by:

- Requiring the active and ongoing intervention of multiple disciplines, one of which must be Physical Therapy or Occupational Therapy;
- Requiring at least 3 hours of therapy at least 5 days per week;
- Being capable of actively participating in and benefiting from the program;
- Requiring medical supervision from the rehabilitation physician as evidenced by face-to-face visits at least 3 times per week and;

- Requiring an intensive and coordinated interdisciplinary approach provided by the rehabilitation team.

In addition to medical necessity criteria, any patient admitted to an IRF must have a discharge plan to return to the community, not a nursing facility. The evaluation period or a trial of inpatient rehabilitation is no longer allowed to determine whether the patient is appropriate for the IRF. All these criteria must be evaluated and documented, if present, at the time of the pre-admission screening for the rehabilitation physician to make the decision about admission. Furthermore, the physician must re-assess those findings with a post-admission physician evaluation that confirms the pre-admission findings. If the patient's condition changes between the pre-admission screen and the actual admission, and the patient no longer meets admission criteria, the rehabilitation physician must document that change and make discharge arrangements within three days.

There are also new requirements regarding Interdisciplinary Care Plans and Team Meetings. The rehabilitation physician must develop the plan of care within 72 hours of the admission to the rehabilitation center. This plan is further evaluated during team meetings, now required weekly, in contrast to the previous requirement of every two weeks. These meetings must have the documented attendance of a rehabilitation nurse, a licensed therapist from each discipline treating the patient (PT, OT, SLP), a social worker and/or case manager, and a rehabilitation physician. At these meetings, staff discuss the patient's rehabilitation needs, solve various clinical and psychosocial problems, and plan the interdisciplinary rehabilitation program. An estimated length of stay is based on the patient's status, prognosis for further improvement, and available care at discharge.

In addition to being familiar with these changes when considering acute rehabilitation for patients, physicians may want to consider access to emergency services in the IRF. Rehabilitation patients often have multiple co-morbidities and exceptionally high acuity, so proximity to

diagnostic and emergency services can be life-saving. Another consideration is accreditation by **CARF International**, (formerly the **Commission for Accreditation of Rehabilitation Facilities**), which advocates for people with disabilities and has reviewed the program. Finally, although the regulations have become more complicated, programs should continue to focus on the needs of disabled patients by providing high quality rehabilitation services.

## REFERENCES

1. (Change Request 6699 to the Medicare Benefit Policy Manual, Revision 112, October 23, 2009)
2. Federal Register <http://edocket.access.gpo.gov/2009/pdf/E9-23708.pdf> (accessed 2/3/10)

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