# Eli's Rehab Report

## Inpatient Insights : Prepare for a Basketful of Changes in the Proposed 2010 IRF PPS

**Admission screening, care planning slated to change.**

The Centers for Medicare & Medicaid Services unveiled its proposed rule for 2010 IRF PPS -- and youll need to brace for more than just a payment update.

**Key:** The proposed revisions clarify requirements for preadmission screening, as well as post-admission treatment planning and ongoing care coordination throughout the inpatient stay.

CMS is also posting draft revisions to the Medicare Benefit Policy Manual that expand upon these proposed changes.

With active input from the rehabilitation community the National Institutes of Health, and medical directors from FIs and MACs, CMS is proposing updates to the current IRF coverage criteria that would better reflect industry-wide best practices, and improve understanding and consistency of medical necessity guidelines, said CMS Acting Administrator **Charlene Frizzera.**

**Prepare to Overhaul Your Admissions Process**

After much discourse via CMS town hall meetings and open door forums, inpatient rehab providers hoped that the admission criteria for IRF stays would be expanded. Unfortunately, the proposed IRF PPS rule does not add new diagnoses to the list that satisfies the 60 Percent Rule compliance threshold. It does, however, propose to change the admissions process.

CMS is proposing that each IRF candidate undergo a preadmission screening conducted by a qualified clinician designated by a rehabilitation physician. This would need to be done no more than 48 hours before admission. CMS is also proposing that the rehab physician review the findings of the preadmission screening and document that she agrees with them before ordering the IRF admission. All documentation of this screening would need to be in the patients medical record.

The new preadmission screening would essentially replace the three-day evaluation, says **Fran Fowler, FAAHC,** managing director, of Health Dimensions Group in Atlanta. And that raises the question, does the PAI now become the purview of the preadmission screener, or is the PAI now under the rehab team that does the plan of care?

**Bottom line:** The new preadmission evaluation would take significantly longer than it currently does -- perhaps even 2 to 2.5 times longer, Fowler predicts.

**Cozy Up to Your Non-Therapist Colleagues**

CMS intends to eliminate the post-admission inpatient assessment (the three-day lookback). But in its place, CMS plans to require a collaborative post-admission evaluation within 24 hours of admission. And youll need to warm up to the idea of more teamwork.

**Details:** CMS wants an interdisciplinary care team -- including nurses -- led by a rehab physician to verify and document that the preadmission observations are still accurate, and if so, begin developing the patients plan of care. And yes, that means nursing gets input on the plan of care. This post-admission collaboration result will determine if the patient is appropriate for IRF care.

In these new rules, Medicare is reinforcing existing policy on the intensity of service delivery, says **Lyndean Brick, JD,** senior vice president of Murer Consultants, Inc. in Joliet, Ill. Thus, these rules signify the need to document and prove the medical necessity for inpatient rehabilitation, Brick adds.

**The kicker:** If coordinating an interdisciplinary team to develop a POC within 24 hours of admission sounds like a lot, CMS wants therapy treatments to begin within 36 hours of admission.

This is going to make for a lot more weekend therapy, especially for people admitted on Fridays,

Fowler says. So if you have little to no staff working weekends, consider changing that.

CMS is proposing that the rehab physician develop the plan of care with input from the interdisciplinary team.

And that team must include a rehab nurse, a social worker or case manager, and a therapist from each discipline involved in treating the patient.

**More meetings:** This interdisciplinary team must meet at least once a week, as opposed to every two weeks.

And the physician would be responsible for the final decisions regarding the patients care.

The proposed rule clearly puts the physician in charge, Fowler observes. However, CMS does not require that the physiatrist be the admitting or charge physician.

**Another change:** CMS proposes that rehab therapy services should generally be provided by one therapist working with one patient, rather than in groups. Group therapies are to be used in IRFs primarily as an adjunct to one-on-one therapy services, CMS states.

**Get Your Program Up to Par**

The proposed rule emphasizes the need for qualified personnel to be giving care. And that means more than having a PT, OT, or SLP credential behind your staffs names. Rehabilitation providers who do not offer truly comprehensive and intensive care that is outcome-based will have trouble operating viable programs, Brick warns.

The emphasis on the qualified personnel raises the question if certification of all rehab team staff will become necessary to meet the term qualified, Fowler says. It at least translates to an extensive orientation program that is specific to inpatient rehabilitation for new staff and certainly new graduates.

**Confusion:** CMS proposes that the physiatrist see the patient at least three times weekly, but this contradicts demonstrating a need for medical necessity, which would require physician supervision 24 hours a day, Fowler points out. This is one area where providers should ask for clarification for the Final Rule.

**Note:** As for payments, CMS proposes increasing IRF PPS payout by $150 million, or 2.4 percent in FY 2010.

The agency also plans to update the CMG relative weights and average length of stay values. Stay tuned for more details on IRF PPS in upcoming issues.