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Eli's Rehab Report

IRFs: Get Answers to Your Biggest IRF Coverage Criteria Questions

CMS elaborates nitty-gritty details of Transmittal 119.

The new coverage criteria that hit inpatient rehab facilities this year were a lot to swallow. And even with Medicare's new guidelines in Transmittal 119, is your list of questions still growing? The Centers for Medicare & Medicaid Services has offered information sheets with some answers. Read on for some important highlights.

Know Your Wiggle Room With Preadmission Screenings

CMS has emphasized that a licensed or certified clinician must conduct the preadmission screening, and the agency reiterates this point in its clarification papers. And among other new duties, the rehabilitation physician is responsible for ensuring the clinician is qualified.

Challenge: So many IRFs now are struggling with how to balance all the new tasks, particularly educating physicians on new responsibilities, points out **Denese Estep, OTR,** senior consultant for DE Consulting LLC in Sherwood, Ark. "It's not so much confusion over what the rules are, as it is, 'how do we do this?'," she says.

The good news: CMS clarifies that the rehabilitation physician does not need to conduct the screening. In fact, "the rehabilitation physician is not required to comment on each individual facet of the preadmission screening," CMS says. "The rehabilitation physician merely needs to document his or her concurrence with the findings and results of the preadmission screening as a whole."

But the clinician shouldn't get too lax on the screening form. The clinician's documentation on the screening form "cannot merely contain 'yes/no' check boxes for whether the patient has a risk for clinical complications," CMS says. The clinician must describe in detail the patient's comorbidities and why these indicate a specific risk that requires physician monitoring.

Watch Your Physician Extender and Assistant Use

With the often heavy use of physician assistants in IRF settings, "there's lots of confusion over, 'what can my PA do now?'" Estep points out. And CMS is setting some firm limits in its latest guidelines.

Example: A physician extender (physician assistants, nurse practitioners, and clinical nurse specialists) may conduct the preadmission screening if he is qualified, but he may not sign off on the preadmission screening, the agency clarifies. Only the rehabilitation physician can do that.

On the up-side, in the post-admission physician evaluations, the rehab physician is not required to repeat the history and physical exam if a physician extender has already completed this step for a patient. Also, a physician extender is allowed to assist the rehabilitation physician in developing the overall plan of care.

What about PTAs and OTAs? "Certified occupational therapy assistants and physical therapy assistants may provide therapy services to beneficiaries under the appropriate supervision of licensed therapists," CMS says.

Many IRF providers have also wondered whether a therapy assistant can stand in for a therapist in the required interdisciplinary team meeting. The short answer is no, according to the clarifications. The "core function" of the interdisciplinary team meeting is to establish or revise the plan of care, and therapy assistants cannot perform these tasks, CMS says. Thus, they "cannot represent their respective disciplines at the meetings."

But this doesn't mean assistants can't be present. "They can attend, but they cannot make any changes to the goals, so

the PT and OT MUST be there," interprets **Dan Gaskell,** IP therapy manager of Carilion Clinic in Roanoke, Va. "In other words, an assistant can be there together with the therapist, but not alone."

Note: CMS offers many more clarifications, which you can find at www.cms.hhs.gov/InpatientRehabFacPPS/04_Coverage.asp#TopOfPage.