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CMS GUIDANCE MAY PREVENT INPATIENT REHABILITATION CLAIM DENIALS

On February 23, 2018, the Centers for Medicare & Medicaid Services ("CMS") issued guidance that may result in fewer denials of claims made by Inpatient Rehabilitation Facilities ("IRFs") for services ("Guidance"). Based on the Guidance, beginning March 23, 2018, Medicare contractors cannot make claim denials exclusively on the basis of a failure to meet the required threshold for therapy time. The new Guidance updates the Medicare Program Integrity Manual to clarify that contractors should rely on "clinical review judgment" to assess the overall necessity of the IRF therapy program based on the documented facts and circumstances of an individual case.

IRF THERAPY COVERAGE REQUIREMENTS

In order to receive reimbursement for IRF care provided to a Medicare beneficiary, it must be considered reasonable and necessary, which is determined by demonstrating the IRF care meets the requirements outlined in 42 C.F.R. §§412.622(a)(3),(4) and (5) and further described in the Medicare Benefit Policy Manual. These coverage requirements include pre-admission screening, post-admission physician evaluation, an individualized overall plan of care, interdisciplinary team meetings, medical supervision and documentation of the intensity of therapy.

Pursuant to the Medicare Benefit Policy Manual, a Medicare beneficiary's IRF medical record must include documentation of a "reasonable expectation that at the time of admission to the IRF the patient generally required the intensive rehabilitation therapy services that are uniquely provided in IRFs." Although this can be determined in various ways, the industry standard for measuring the intensity of these therapy services is typically demonstrated by providing at least 3 hours of therapy per day, at least 5 days per week or at least 15 hours per week. Medicare contractors have been denying claims for IRF care based on the failure to document the requisite 3 hours per day, even if the beneficiaries missed that mark by mere minutes. Due to the documentation requirements for IRF stays, failure to meet the required therapy threshold means denial of the claim for the patient's entire IRF stay – not just the therapy session that missed the 3-hour standard. According to IRFs, patients may miss the required therapy time due to medically necessary screenings or services, patients being too ill to sustain 3 hours (or more) of therapy in a day or for something as simple as a bathroom break.

NEW GUIDANCE

The new Guidance clarifies that Medicare contractors reviewing IRF claims must verify the IRF coverage requirements are documented in accordance with the guidelines in the Medicare Benefit Policy Manual, but contractors "shall not make absolute claim denials based solely on a threshold of therapy time not being met." Instead, if the current standard of 3 hours per day or 15 hours per 7-day period is not met, the claim must undergo further review and the contractor must use its clinical judgment to assess the medical necessity of an IRF stay.

PRACTICAL TAKEAWAYS

IRFs should continue to thoroughly document all coverage requirements, including therapy intensity, as described in the Medicare Benefit Policy Manual to demonstrate compliance with the reasonable and necessary requirements for reimbursement of IRF claims. A Medicare beneficiary's IRF medical record should include sufficient detail to demonstrate the patient required the intensive rehabilitation services provided by IRFs, regardless of whether the therapy hour thresholds were met. However, based on this new Guidance, IRFs should be able to anticipate fewer claims denials on the basis of therapy time alone.

If you have any questions regarding this new guidance, please contact:

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