Clarification regarding whether email or BlackBerry® transmissions are an allowable means of documenting the rehabilitation physician's review and concurrence with the preadmission screening prior to an IRF admission.

As we have said in the "Series 1" clarifications that are available on the "Coverage Requirements" page of the IRF PPS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Coverage.html:

"A rehabilitation physician must review and concur with the findings and results of the preadmission screening after the screening has been completed and prior to the IRF admission. By concurrence, we mean that the rehabilitation physician must either sign and date the original document or, if reviewing from an off-site location, sign and date a copy of the document and fax it to the IRF. This may be done either on the preadmission screening form itself or on a separate document or electronically, as long as it is done prior to the IRF admission."

Efforts are currently underway at CMS to develop overall policies for the use of electronic signatures (e-signatures) for Medicare transactions. Until such efforts are completed and new policies have been established, we cannot allow the preadmission screening concurrence to be documented through any other means except as a signature on the original document or on a copy of the document that is faxed to the IRF.

Clarification regarding whether the discharge dates on the IRF patient assessment instrument (IRF-PAI) and the discharge dates on the IRF claim must be the same.

As we stated on the May 31, 2012 IRF Coverage Requirements National Provider Call, we believe that the discharge dates on the IRF-PAI should always match the discharge dates on the IRF claims. Thus, we removed language from the IRF-PAI Training Manual (effective October 1, 2012) that may have led providers to believe that they could put different discharge dates on the IRF-PAI than on the claim.

Although previous guidance in the IRF-PAI Training Manual suggested that patients could be downgraded from a Medicare Part A IRF stay by "discharging" the patient on the IRF-PAI when the patient no longer required an IRF level of care, this guidance is no longer consistent with Medicare regulations. As stated in Chapter 1, Section 110.3 of the Medicare Benefit Policy Manual (Pub. 100-02), "Since discharge planning is an integral part of any rehabilitation program and must begin upon the patient's admission to the IRF, an extended period of time for discharge from the IRF would not be reasonable and necessary after established goals have been reached or the determination has been made that further progress is unlikely." We believe that it is in the patient's best interest for the IRF to begin the discharge planning process early and continue it throughout the IRF stay. Thus, although we allow a brief period for the IRF to find alternative placement for a patient who no longer meets the IRF coverage criteria, an extended stay in the IRF for such patients is not warranted.

In the very rare case in which it may become apparent that the patient's discharge from the IRF is going to be delayed for an extended period of time, the IRF should provide the patient with an Advance Beneficiary Notice (ABN) informing the patient that he or she may be liable for any

remaining charges. The IRF should also use occurrence code 76 on the IRF claim for the remaining days to indicate that those days are not Medicare-covered under the IRF prospective payment system. Otherwise, the IRF claim will continue to be considered a Medicare Part A stay and will continue to be subject to review under the IRF coverage requirements.

Clarification regarding whether all participants in the weekly interdisciplinary team meetings are required to sign the documentation of the meetings.

Signatures from the participants in the weekly interdisciplinary team meetings are not required. Chapter 1, Section 110.2.5 of the Medicare Benefit Policy Manual (Pub. 100-02) requires only that the documentation, "include the names and professional designations of the participants in the team conference."

Clarification regarding whether the documentation of the intensive rehabilitation therapy program in IRFs must be reported in minutes or may be reported in 15-minute increment units.

It is up to the IRF exactly how they wish to document the number of minutes of therapy provided to the patient. However, therapy minutes cannot be rounded for the purposes of documenting the required intensity of therapy provided in an IRF (for example, 8 minutes of therapy cannot be rounded up to a 15-minute increment of therapy, as is sometimes done in other settings). A 15-minute increment unit reported for an IRF patient must mean that the patient actually received the full 15 minutes of intensive therapy.