Audience Questions from the AAPM&R Webinar: IRF Documentation Compliance

1. Are there specific documents that are not sufficient if completed by a midlevel and timely attested by the attending physician?
   The PAPE must be completed by the rehab physician. The following documents can be completed by a midlevel/physician extender and signed by the rehab physician:
   - pre-admission screening,
   - plan of care,
   - notes of team meetings, and
   - admission order.

2. If I understood correctly, a rehab APN (designated personnel) completing PAS is insufficient UNLESS reviewed and co-signed by an attending (similar to tam conference documentation). Is this correct?
   That is correct—the rehab physician MUST review and document that he or she concurs with the PAS. Concurrence is usually documented by the physician's signature.

3. Does a patient need daily evaluation including weekends?
   Under Medicare requirements, no. The requirement is that the patient be seen at least three times a week.

4. Is it necessary to document why patient's therapy is being distributed over 7 days instead of 5? Does this have to be decided at admission or can it be charged later if someone cannot tolerate 3 hours a day?
   It is best practice to document the reason why a patient is not participating in three hours of therapy per day, which is the requirement. The choice to extend therapy beyond five days to a full seven days is not relevant unless the patient is not participating in a full three hours on each day therapy is provided.

5. Can post admission physician evaluation be included as part of H & P?
   Under coverage criteria for IRFs, there is no requirement for an H&P other than as a component of the PAPE; however, other requirements may exist that necessitate the completion of an H&P separate from the PAPE.

6. What type of activities count for the 20-hour medical director requirements?
   This is not specified in Medicare guidance. Generally, the services must be to the benefit of the IRF and its patients, so time spent on patient care would be included, as well as time spent on administrative tasks for the IRF.

7. Please discuss the situation where a patient is seen as a consult prior to transfer to IRF. 2 H & Ps?
   Any documentation of the consult, other than the creation of a formal pre-admission screening, would be in addition to the required IRF documentation.

8. If a patient is transferring to our IRF from the same hospital but on a different floor, and we see them off floor and start our notes before they arrive at IRF, are we allowed to sign the notes before they physically arrive on our floor and are "admitted?" Or do we have to wait until they get there before signing the documentation? I had heard before that if the time stamps don't match up that it could trigger audits, but I wasn't sure if this was true or not.
   Other than the pre-admission screening, all IRF documentation must be created AFTER the patient's actual admission to the IRF. If timestamps reflect that documentation was created pre-admission (again, other than the PAS), that documentation may well be disregarded by any auditor. It would not necessarily trigger audits, since the documentation is generally not available to the auditors until after the audit is initiated, but it would be grounds for potential denial of claims if audited and then additional audits in the future.

9. Regarding the three weekly visits, is there a maximum number of visits per week? I tend to round five days per week. My associate only three times.
   There is no limit on weekly physician visits. The only caveat I will add is that the physician is bound to only bill for medically necessary services, the same as any other provider or supplier, so excessive visits without medical justification can generate audit risk for the individual physician upon submission of E&M claims for the services.