

Regulations You Need to Know

Is Medicare Becoming Medi-SCARE?
(Not if you work it right)

Participants Will

- Identify the federal requirements that preserve **IRF** classification and payment status
- Know IRF regulatory source documents
- Apply Medicare admission and documentation criteria to individual patients
- Recognize FY 2027 policy changes and translate them into operational controls



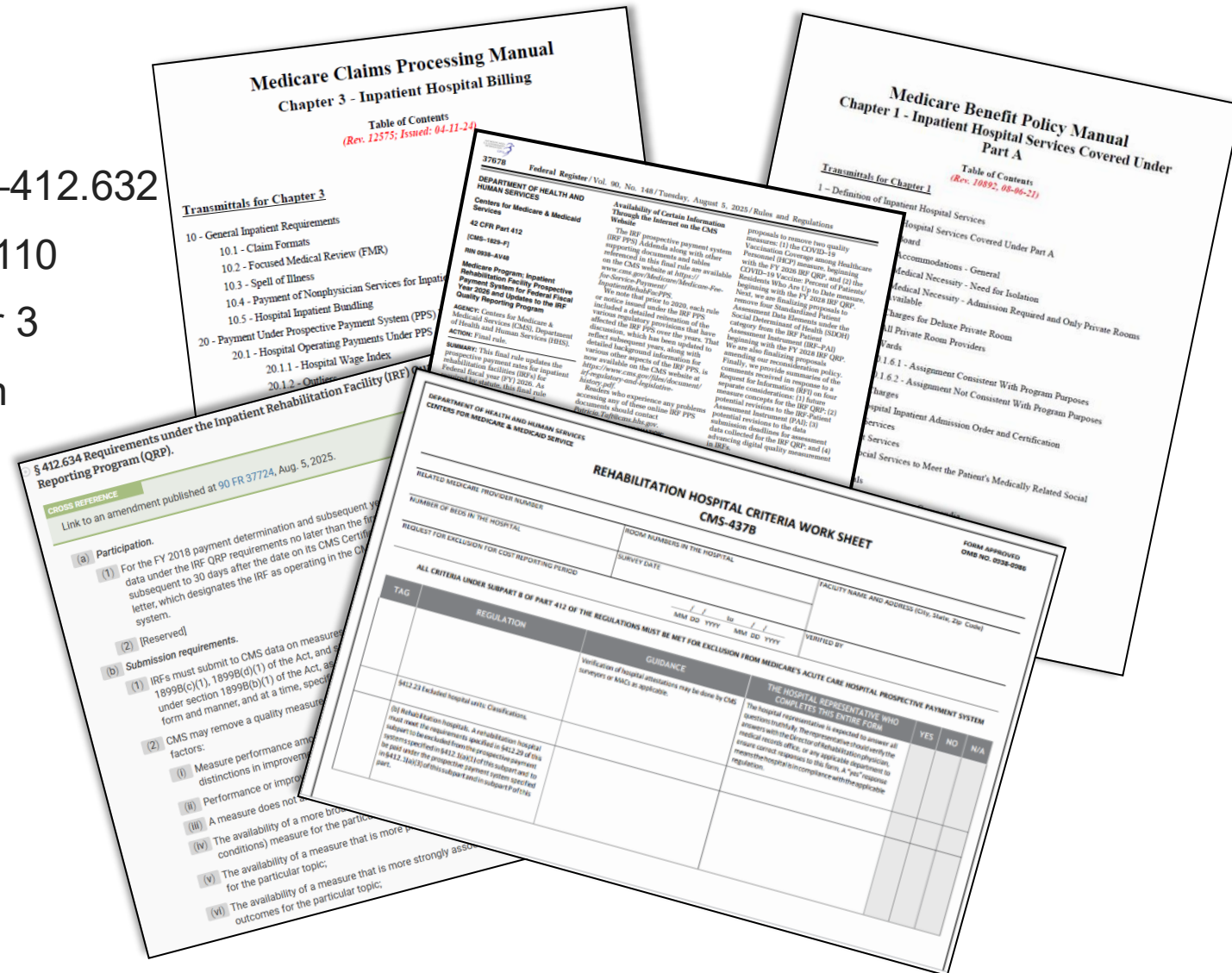
Starting Point

- An IRF provides an acute hospital level of care
- Annually, CMS verifies IRF classification criteria is met and that 60% of all admits/discharges fall into one of the approved CMS diagnoses.
- IRFs are exempt from the acute hospital DRG payment system and are paid under the IRF PPS if classification criteria are met.
- Each Federal Fiscal Year (starting October 1st) IRF rules can change
 - Payment adjustments
 - Operational/documentation adjustments
- The patient record must support both the need for intensive rehabilitation and the need for hospital-level rehabilitation care



Core Source Documents

- 42 CFR 412.20–412.29 and 42 CFR 412.600–412.632
- Medicare Benefit Policy Manual, Chapter 1, §110
- Medicare Claims Processing Manual, Chapter 3
- CMS Form 437A or 437B for IRF classification
- FY 2027 IRF PPS final rule, CMS-1845-F
- Current IRF-PAI manual
- QRP guidance
- Accrediting Agency Standards



Classification Requirements

- The hospital or unit meets applicable acute-care licensing and Conditions of Participation
- CMS verifies IRF status at least every three years, apart from the annual 60% rule review (855A on PECOS system)
- The IRF maintains designated beds, qualified rehabilitation leadership, and a multidisciplinary team
- A Medical Director provides required oversight. Medical Director must have a minimum of 2 years of experience managing and caring for inpatient rehabilitation patients (437A or B)

IRF Unit- 20 hours

Freestanding IRF- Full-time

- The facility satisfies the 60% rule through presumptive or medical-record review methodology

SOM Exhibit 127
Attestation Statement for Exclusion from the IPPS
Covering the Period from _____ (Month/Year) to the Present
(Based on the Dates Contained in the Letter from the State Agency)

Name of State Agency Director _____
Name of State Agency _____
Address _____
City, State, Zip _____
Date _____

Dear (State Agency Director):

This Attestation Statement has been completed and signed by both our hospital Administrator or Chief Executive Officer (including hospitals with excluded units) and the Director of Rehabilitation (physician).

Based upon our personal knowledge and belief, we attest that the responses on the attached Rehabilitation Criteria work sheet (Form CMS 437A or CMS 437B) are true and correct, and that (name of IPPS-Excluded Hospital or Unit) has met, meets and will continue to meet all the applicable requirements for exclusion from the IPPS for the period beginning (first day of hospital's fiscal year or cost reporting period), as set out in Subpart B of 42 CFR Part 412. We understand that the Centers for Medicare and Medicaid Services (CMS) or its representative has the right to conduct an on-site survey at any time to validate whether the statements made on the attached work sheet are

Medical Director Hours and Payment

Medical Director _____

Monthly Time Record

Month: _____

Activity	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	Total	Activity Key	
Days 1																				0.00	1. Patient Care	12. Quality Improv.
2																				0.00	2. Team / Patient Care Conference	13. Marketing/Phys. Rel.
3																				0.00	3. Patient & Family Conference	14. Public/Community Ed.
4																				0.00	4. Administrative Meetings	15. Survey Compliance
5																				0.00	5. Clinical Employee Meetings	16. Patient Satisfaction
6																				0.00	6. Admission Meetings	17. P & T Committee
7																				0.00	7. Medical Staff Meetings	18. IC Committee
8																				0.00	8. Utilization Management	19. Other:
9																				0.00	9. Clinical Staff Oversight	Interviews
10																				0.00	10. Training/Inservices	Peet to peer x 3
11																				0.00	11. Program Dev./Med. Protocols	Medicare

The time spent in direct patient care is not included in calculation of time paid

Total Hours	0.00
Less: Colmn #1 & 3	0.00
Non Patient Care Hrs	0.00

Hourly Rate Calculation

Hourly Rate	
Non Patient Care Hrs	0.00
Total Monthly Stipend	\$ -

The 60% rule

- At least 60% of the IRF's applicable inpatient population must have one of the 13 qualifying conditions
- The calculation includes Medicare and non-Medicare patients
- CMS uses presumptive compliance when coding meets the qualifying criteria
- Medical-record review may establish compliance when presumptive methodology does not

Categories 1–5

- Stroke
- Spinal cord injury
- Congenital deformity
- Amputation
- Major multiple trauma

Categories 6–9

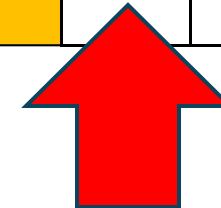
- Hip fracture
- Brain injury
- Neurological disorders
- Burns

Categories 10–13

- Active polyarticular rheumatoid arthritis, psoriatic arthritis, or seronegative arthropathies
- Systemic vasculidities with joint inflammation
- Severe or advanced osteoarthritis
- Knee or hip replacement meeting specified criteria

The 60% Annual Review Process

Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
				Cost Report Year											
60% Rule Measurement Time Frame															



- CMS evaluates each compliance review year
- The first review uses Medicare fee-for-service and Medicare Advantage data
- If needed, the second review may include records for all payers
- Maintain an internal year-to-date

60% rule: manage the denominator every month

60%

Required compliance threshold

12 months

Standard review period

4 months

Review begins before the cost-report year

Operating controls

- Track presumptive and nonpresumptive cases by discharge
- Validate etiologic and comorbidity coding before submission
- Forecast the full review-period denominator
- Escalate trend risk before admission strategy changes

Classification risk

Failure can jeopardize classification as an IRF and payment under the IRF PPS. This is enterprise risk, not a coding metric.

Admission criteria

- Multiple therapy disciplines, with one being physical therapy or occupational therapy
- An intensive rehabilitation therapy program (3 hours of therapy, 5 days a week or 15 hours weekly)
- Ability to actively participate and benefit from an intensive rehab program
- Rehabilitation physician supervision
- An interdisciplinary team approach
- A reasonable expectation of measurable improvement

Required early-stay documentation

- Preadmission screening completed within the 48 hours immediately before admission
- Rehabilitation physician review and concurrence before admission
- Admission orders prior to or at time of admission
- History and physical documented on the chart within 24 hours
- **Initial interdisciplinary team conference by the end of day 4***
- Individualized overall plan of care completed by the end of day 4
- IRF-PAI completed by end of day 3

* Effective October 1, 2027

STRONG Concurrence

“I reviewed the final preadmission screen and concur that the patient requires and is reasonably expected to benefit from IRF care based on...”

Strengthening the Preadmission Screening

- Describe prior level of function and the patient's current assistance needs with objective detail
- Connect comorbidities and risks to active physician management and rehabilitation nursing
- Identify the disciplines required and explain why a coordinated intensive program is necessary
- State realistic functional outcomes, estimated length of stay, and discharge destination
- Address why a less intensive setting cannot safely or effectively meet the patient's needs



Plan of Care

- At admission, the record must support a reasonable expectation that the patient meets every requirement in 42 CFR §412.622(a)(3)
- Coverage depends on the patient's individual medical and functional needs
- A qualifying diagnosis alone does not establish medical necessity
- The IRF must reasonably expect measurable, practical improvement during the stay

CLINICAL PROBLEM	IRF INTERVENTION	MEASURABLE OUTCOME
Orthostasis + falls	Medication adjustment; vitals during therapy; PT gait training	Ambulate 150 ft with supervision without symptomatic BP drop
Dysphagia + aspiration risk	SLP strategy; diet oversight; physician monitoring	Consume prescribed diet without aspiration indicators
Cognitive impairment	Structured cues; OT/SLP; caregiver training	Complete medication routine with set-up and cues

FY 2027 final rule: the operational changes

All therapies within 36 hours

Each required therapy discipline must begin within 36 hours of admission. This replaces inconsistent readings that allowed only one discipline to begin in that window.

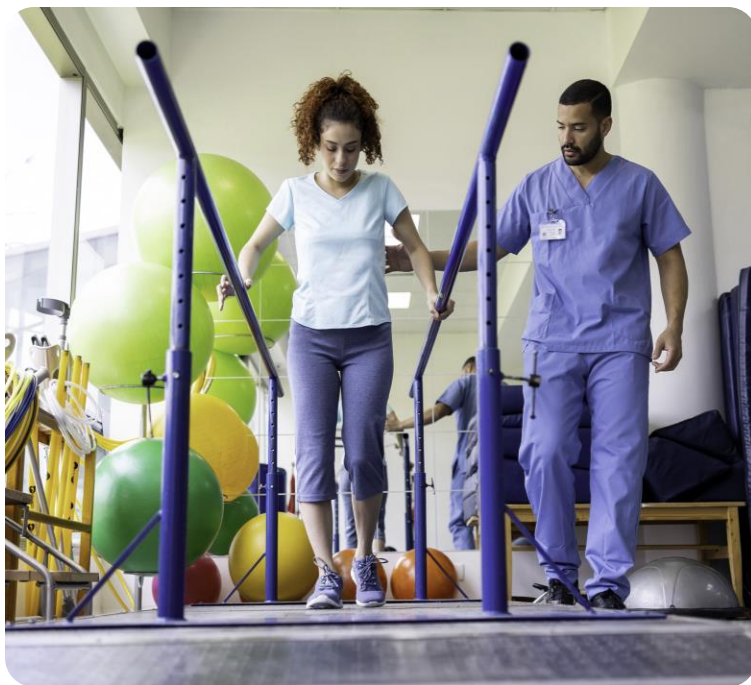
Initial IDT meeting by day 4

Complete the first interdisciplinary team meeting on or before the fourth day of admission so it aligns with the individualized overall plan of care.

Weekly timing anchored

Conduct later meetings no more than seven days from the date of the prior required meeting, beginning with the initial meeting.

Therapy Intensity



- Use the common standard of three hours per day on at least five days each week when clinically appropriate
- The 15-hours-over-seven-days approach applies when the patient's needs justify the alternative pattern
- Specify expected intensity, frequency, and duration in the individualized plan of care
- Document missed or modified therapy, the clinical reason, and the plan to continue the intensive program
- Group and concurrent therapy require individualized clinical judgment and accurate documentation



15-hour weekly option

Explain why 15 hours over 7 days is appropriate; do not treat it as an automatic alternative.



Interrupted or missed therapy

State the medical reason, impact, mitigation, and revised plan.



Slow or uneven progress

Describe barriers, clinical response, goal reassessment, and why continued IRF remains reasonable.



Discharge-date change

Connect new medical/functional facts to the revised plan and destination.

Document exceptions with the same rigor as the standard

36-Hour Readiness Checklist

- Identify every required therapy discipline before admission
- Schedule evaluations and treatment to begin within 36 hours of the admission time
- Create an escalation process for weekends, holidays, staffing gaps, and unexpected clinical changes
- Audit the actual therapy start time by discipline, not merely the order or evaluation date
- When the patient cannot begin a planned discipline, document the facts and promptly reassess coverage risk



Physician Supervision

- The patient must require active and ongoing therapeutic intervention by a rehabilitation physician
- The physician completes at least three face-to-face visits each week throughout the stay
- Beginning in the second week, a qualified nonphysician practitioner may conduct one of the three required visits when permitted by state law
- Visits must address the patient's medical and functional progress and modify the course of treatment when needed

“Stable. Continue therapy.”

This does not demonstrate a medical + functional assessment or explain how management supports rehabilitation.

Not enough

Specificity beats volume.

- Medical status and active risks
- Functional response to therapy
- Barriers: pain, fatigue, cognition, endurance, behavior, complications
- Physician decisions and treatment changes
- Impact on participation, safety, goals, or discharge plan

Stronger structure

Interdisciplinary team requirements

- The rehabilitation physician leads the conference
- Required participants include a registered nurse with specialized rehabilitation training or experience, a social worker or case manager, and a therapist from each treating discipline
- The team reviews progress toward goals, discharge barriers, treatment modifications, and discharge planning providing coordinated care
- The rehabilitation physician documents concurrence with team decisions
- For admissions on or after October 1, 2026, the initial meeting occurs by day 4 and establishes the weekly cadence

PROGRESS

What changed since the prior meeting?

BARRIERS

What is slowing or threatening progress?

DECISIONS

What will the team change—and why?

NEXT TEST

What evidence will show the change worked?

Team notes should resolve barriers—not just list disciplines

Make the Reasoning for Medical Necessity Unmistakable

- The preadmission screening identifies the expected medical and functional need
- The physician's documentation explains why the patient requires IRF-level medical management
- Therapy evaluations translate impairments into measurable goals and an intensive treatment plan
- Nursing documentation shows rehabilitation nursing needs and risks across the full day
- Team conference notes reconcile progress, barriers, and changes to the plan

TIMELY	PATIENT-SPECIFIC	CONNECTED
Right document right clock	Facts and decisions not generic phrases	Medical status ↔ function ↔ plan

Brief Exceptions To Therapy Intensity

- A limited number of days may fall below the expected intensity when an unexpected clinical event interrupts therapy
- The record should identify the event, its effect on participation, medical management, and the plan to resume intensive rehabilitation
- The exception cannot substitute for a patient who lacked a reasonable expectation of tolerating intensive therapy at admission
- A recurring pattern warrants reassessment of the plan and continued IRF medical necessity

FY 2027 Payment and QRP updates

2.3% payment update

CMS finalized a 3.2% market-basket increase less a 0.9 percentage-point productivity adjustment. CMS estimates \$340 million more in IRF payments.

Outlier and rural changes

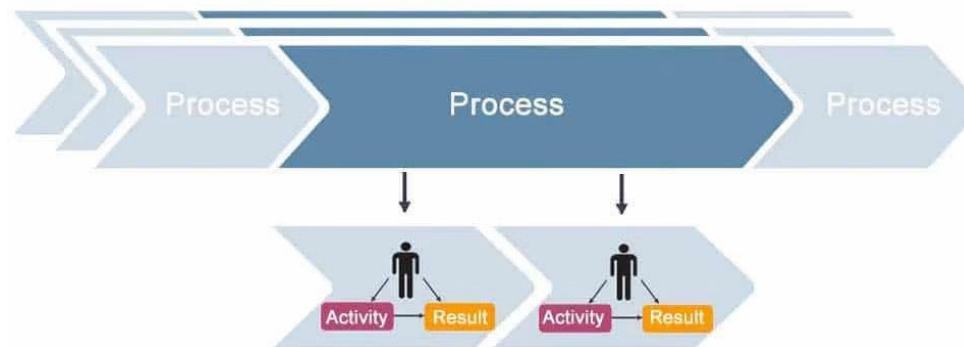
The outlier threshold continues to target 3% of total payments. FY 2027 completes the three-year phase-out for affected rural-to-urban reclassifications.

QRP deadline accelerates

Beginning with FY 2029 QRP, CMS shortens the assessment-data submission window from 4.5 months to about 45 days. Build faster validation and correction workflows.

IRF QRP: Operational Preparation

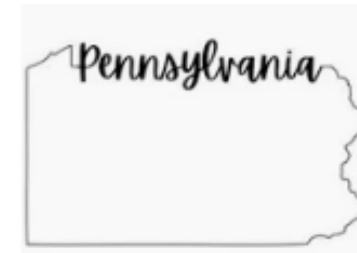
- Map each IRF-PAI data element to its clinical source and accountable owner
- Move validation closer to discharge rather than relying on quarter-end cleanup
- Monitor accepted-versus-rejected submission status and correction queues
- Prepare for the approximately 45-day deadline that begins with FY 2029 QRP
- Remember that failure to meet QRP requirements can reduce the annual payment update by two percentage points



WORKFLOW

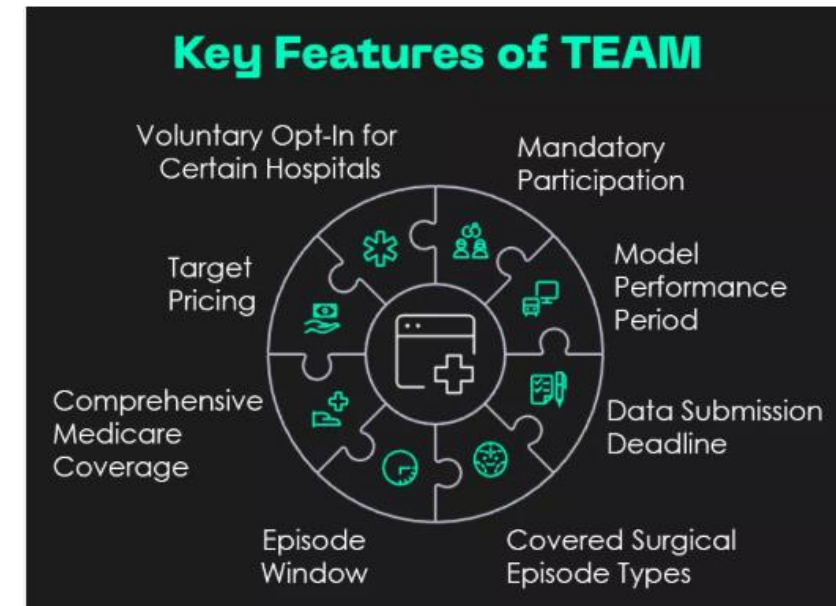
Review Choice Demonstration

- RCD remains a central medical-review risk for participating IRFs
- Choice 1 uses pre-claim review and supports provisional affirmation before claim submission
- Choice 2 uses postpayment review and increases recoupment exposure when documentation fails
- Track affirmation and non-affirmation reasons by criterion, clinician, and referral source
- Treat the FY 2027 therapy and IDT timing rules as auditable requirements beginning October 1, 2026



TEAM Model and the IRF opportunity

- TEAM began January 1, 2026 and runs through December 31, 2030
- Selected acute-care hospitals remain accountable for cost and quality through 30 days after surgery
- The five episode categories include CABG, major bowel procedures, lower-extremity joint replacement, surgical hip and femur fracture treatment, and spinal fusion
- IRFs should demonstrate timely access, strong outcomes, low avoidable returns to acute care, and reliable data exchange
- TEAM's SNF three-day stay waiver does not create an IRF coverage waiver



Hospital Price Transparency

- Hospital price transparency requirements continue to apply to IRFs that meet the definition of hospital
- Maintain the machine-readable file and consumer-friendly display or price-estimator pathway required by CMS
- Use the current CMS data dictionary, file naming convention, and required affirmation language
- Assign ongoing ownership for completeness, accessibility, and updates rather than treating publication as a one-time project
- Monitor CMS rulemaking and enforcement guidance for format and data-element changes



Audit Priorities for Fall 2026

- All required therapy disciplines begin within 36 hours of admission
- The first IDT meeting occurs by day 4 and later meetings follow the seven-day cadence
- The preadmission screening supports all admission criteria before the admission decision
- Physician, nursing, and therapy documentation present a consistent account of medical necessity
- 60% rule coding evidence remains complete and retrievable
- QRP validation workflows can support the shorter future submission deadline



Thank you

Questions and Discussion

