JF INPATIENT REHABILITATION FACILITY (IRF) CLINICIAN'S CHECKLIST

This checklist is intended to provide healthcare providers with a reference for use when responding to documentation requests for this service. It is not intended to replace the published guidelines or policy.

Policy References

- CMS IOM 100-02, Chapter 1, Section 110

Documentation References

- CMS IOM 100-02, Chapter 1, Section 110
- CMS Follow Up Information for IRF Coverage Requirements
- CMS Inpatient Rehabilitation Therapy Services: Complying with Documentation Requirements

Medical Documentation

Coverage is possible when the following documentation is submitted:

- ☐ IRF Admission Orders
- ☐ History and physical reports (include medical history and current list of medications)
- ☐ IRF discharge summary
- ☐ Preadmission Screening (PAS)
- Signed and dated overall plan of care
  - ☐ Individualized
  - ☐ Medical Prognosis
  - ☐ Anticipated interventions, outcomes, and discharge destination
  - ☐ Intensity, frequency, and duration of each therapy involved
- ☐ IRF Patient Assessment Instrument (IRF-PAI)
- ☐ Rehab practitioner fact-to-fact visits (Three required each week of IRF stay)
- Interdisciplinary Team Conference

- [ ] Once per week at minimum
- [ ] Lead by rehab physician
- [ ] Documented participation by professionals from each of the follow disciplines:
    - Rehabilitation physician
    - Registered Nurse (RN)
    - Social worker or case manager (or both)
    - Licensed/certified therapist from each therapy discipline involved in treating the patient
    - Documentation from all therapy disciplines involved, one of which must be physical therapy (PT) or occupational therapy (OT)
        - [ ] Initial evaluation
        - [ ] Treatment encounter notes
        - [ ] Therapy minutes log
        - [ ] Discharge summary
- [ ] Practitioner, nurse, and ancillary progress notes
- [ ] Diagnostic test, radiological reports, lab results, pathology reports, and other pertinent interpretations
- [ ] Medication Administration Record (MAR) and/or infusion flowsheet documenting the quantity administered including a dose, route, and frequency given
- [ ] Vital sign records, weight sheets, and treatment records
- [ ] Itemization of services
- [ ] Advance Beneficiary Notice of Noncoverage (ABN)
- [ ] Signature log or signature attestation for any missing or illegible signatures within the medical record (all personnel providing services)
- [ ] Facility process of how electronic signature is created using electronic health record