TAR Criteria for Acute Inpatient Intensive Rehabilitation (AIIR)

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Definition

Acute Inpatient Intensive Rehabilitation (AIIR) is intended to help the physically or cognitively impaired patient to achieve or regain his or her maximum potential for mobility, self-care and independent living by restoring maximum independent function, resulting in a sustained higher level of self-care and discharge to home or other community setting, or to a lower level of care, in the shortest possible time.

This section addresses *Treatment Authorization Request* (TAR) document requirements and medical necessity criteria for fee-for-service AIIR Services. Refer to the *Inpatient Rehabilitation Services* section of the appropriate Part 2 provider manual for additional billing information regarding AIIR services. For instructions on how to complete a TAR for AIIR services, refer to the *TAR Request for Extension of Stay in Hospital (Form 18-1)* section of the Part 2 manual.

Criteria

AIIR Admission Criteria

The following minimum required documents should be submitted with the TAR.

A. Pre-Admission Screening Documentation

- CMS defines pre-admission screening as a detailed and comprehensive evaluation of the patient's condition and need for rehabilitation therapy and medical treatment. It is the initial determination of whether the patient meets the requirements for AIIR admission
- ‹‹Can be performed by a licensed or certified clinician(s), but it must be concurred or approved by the Rehabilitation Physician››
- Should be performed within 48 hours prior to admission
- May be done in an acute or outpatient setting, but the documentation must specifically indicate the patient's need for AIIR
- Should not indicate a trial period, as they are no longer considered reasonable and necessary
- Should document patient's ability to actively participate in rehabilitation

Evaluation should include:

- Potential Eligible Diagnoses requiring rehabilitation, such as but not limited to the following categories:
  - Central nervous system, such as:
    - ❖ Cerebral vascular accident
    - ❖ Spinal cord injury
    - ❖ Traumatic brain injury
    - ❖ Neurosurgery
    - ❖ Major multiple trauma
  - Neurological disorders, such as:
    - ❖ Acute Multiple Sclerosis relapse
    - ❖ Parkinson's disease
    - ❖ Guillain-Barre syndrome event
    - ❖ Post-polio relapse
    - ❖ Muscular Dystrophy
    - ❖ Orthopedic conditions – complex types of fracture, amputation, joint replacement and spine conditions with comorbidities, such as bilateral, Body Mass Index greater than 50 or patient age of 85 years or older
  - Other diagnoses, such as cardiac, respiratory, cancer, deconditioning, or burns
- Current medical, surgical, and psychological stability
  - Functional deficits in activities of daily living (ADL), Mobility, etc., that require two or more therapy disciplines, such as:
    - ❖ Physical Therapy (PT)
    - ❖ Occupational Therapy (OT)
    - ❖ Speech Language Pathology (SLP)
    - ❖ Psychological-cognitive
    - ❖ Prosthetic-orthotics
    - ❖ Social

- Documentation of current nutritional approaches and status
- Social Support (for example: family, caregivers, home setting)
- Expected length of rehab stay
- Rehab limitations and impairments (for example: ADL, mobility, cognition)
- Rehab disciplines needed (for example: PT, OT, nursing, SLP, prosthetic-orthotics)
- Rehab potential for functional gains, and expected level of improvement

Potential limiting factors of admission and continued AIIR services:

- Analgesia that requires continuous infusion from pain pump mechanism
- Hemodynamic, Respiratory, Surgical instability
  - Unstable vital signs
  - Telemetry or cardiac monitoring or ventilator (if tracheotomy is present, must be able to tolerate trach capping)
  - Bed-rest requirement (unstable fracture or weight-bearing status identified)
  - Active bleeding
  - High output from chest tube(s)
- Ongoing treatments (for example: dialysis, radiotherapy) that interfere with participation
- Mental Health
  - Acute psychiatric issues such as Homicidal Ideations or Suicidal Ideations
  - Disruptive or uncontrolled aggression
  - Severe dementia- must be able to participate in or follow rehab program
- Inability to make significant functional gains and measurable improvements

B. Individualized Overall Plan of Care

- Must be completed within first four days of admission
- Must support medical necessity of admission
- Must detail patient's medical prognosis and anticipated therapeutic interventions
  - Expected intensity (number of hours per day)
  - Expected frequency (number of days per week)
  - Expected duration (number of days of stay)

- Must detail anticipated functional outcome
- Must detail discharge destination from stay

C. CMS IRF-PAI

- Must be included in patient's medical records
- Must have date, time, and signature

Medical Necessity Criteria

The documents listed above (A through C) will be used to determine medical necessity at the time of admission, including the following concepts and criteria (E through I):

D. Involvement of Multiple Therapy Disciplines

- Active and ongoing intervention (PT, OT, SLP or prosthetic-orthotics), at least one of which must be PT or OT

E. Active Patient Participation

- Should be documented on the Pre-Admission Screening
- Reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program
  - Patient's condition and functional status can reasonably be expected to make measurable improvement within the period of time of the intensive rehab program
  - Expect practical value to improve the patient's functional capacity or adaptation to impairments

F. Rehabilitation Physician Supervision

- Face-to-face visits at least three days per week; beginning the second week, a Non-Physician Practitioner may perform one of the three weekly required face-to-face visits
- Assess the patient both medically and functionally to modify the course of treatment as needed

G. Intensive Rehabilitation Therapy Program

- Three hours of therapy per day at least five days per week or at least 15 hours of intensive rehabilitation therapy within a 7-consecutive day period, beginning with the date of admission
  - Weekends and holidays are not excluded from therapy requirements
- Therapy minutes cannot be rounded up
- Therapy evaluation must be done within 36 hours from midnight on the day of admission
- Standard of care is one-on-one therapy
- Group therapy is acceptable but must be well-documented and should not exceed 25 percent of the required 15 hours per week of treatment time
- Family conferences do not count towards therapy
- Break in service is allowed (not to exceed three consecutive days) for certain medical exceptions and does not affect the determination of the medical necessity criteria per day
- If the patient is unable to continue therapy, then provider should revise the plan of care and transfer or discharge the patient

H. Coordinated Interdisciplinary Team (IDT) Approach

- Complexity of the patient's condition and rehab goals must be indicated in the preadmission screening
- Team conferences must be held once a week, defined as a 7-consecutive day period beginning with date of admission

- IDT Evaluation (for example: PT, OT, SLP, neuropsychology, respiratory therapy or social work) should identify the following:
  - Premorbid functional level (for example: independent, durable medical equipment use, community, mobility)
  - Current functional status (for example: maximum, moderate, or minimum assistance with ADL, mobility)
  - Participation potential (for example: willingness and cognitive ability to follow program)
  - Nutritional or swallowing evaluation
  - Physical or mental precautions (for example: fall risk, mild dementia or disorientation requiring one-on-one assistance, weight precautions, dysphagia risk)
  - Case manager or social worker evaluation
  - Prior level of function
  - Identification of social and family support
  - Discharge disposition planning to home or community setting
- IDT participation by professionals, as appropriate, from the following disciplines specialized and trained in rehab services:
  - Rehab physician (physiatrist)
  - Rehab registered nurse
  - Case manager or social worker
  - Licensed or certified therapist from each discipline involved in care
- IDT conferences must focus on:
  - Assessing patient’s progress toward rehab goals
  - Considering possible resolutions to any problems that could impede patient’s progress toward goals
  - Reassessing validity of rehab goals previously established
  - Monitoring and revising treatment plan as needed
  - Documenting justification for continued stay demonstrating patient’s measured functional improvements that are ongoing, sustainable and of practical value as measured against the patient’s condition at the start of treatment

Legend

Symbols used in the document above are explained in the following table.

Symbol	Description
‹‹	This is a change mark symbol. It is used to indicate where on the page the most recent change begins.
››	This is a change mark symbol. It is used to indicate where on the page the most recent change ends.