preadmission screening, and that it must be supported by the information in the post-admission physician evaluation and the overall individualized plan of care. We do not believe that it is appropriate to provide 4 days (at which point the IRF would generally receive a full CMG payment for the patient) or an undefined amount of time for the IRF to determine whether the patient meets the IRF medical necessity criteria. This determination should be made at the time of admission to the IRF.

Comment: Several commenters expressed concerns that the ''3-hour rule'' could preclude access to IRF care for certain patients who, for one reason or another, cannot participate in at least 3 hours of intensive therapy at least 5 days per week, but who nonetheless could benefit from treatment in an IRF. Several of these commenters suggested that this rule would violate *Hooper* v. *Sullivan,* No H–80–99 (PCD) (D Conn. July 20, 1989). For this reason, some commenters suggested that we allow exceptions to this rule for patients who need other rehabilitation services, but cannot tolerate 3 hours per day of physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics therapy. Some commenters also suggested that we allow for exceptions to this rule for patients who require a lower intensity of therapy services but for whom an IRF admission is the only way that they can participate in a lower intensity of therapy services. In addition, one of the commenters suggested that, in some cases, we should provide more flexibility for meeting the needs of the individual patient by requiring instead that the IRF provide intensive therapy at least 15 hours per week, to be averaged over the week as necessary.

Response: We believe that patients admitted to IRFs should generally require and be reasonably expected to benefit from the *intensive* rehabilitation therapy services that are uniquely provided in IRFs. If patients do not need the intensity of services uniquely provided in IRFs, or benefit from them, then it is not clear to us why they would be admitted to an IRF.

By order of the Court in *Hooper* v. *Sullivan,* rules of thumb cannot serve as the basis of a coverage denial. In keeping with this ruling, the reasonable and necessary test for coverage of an IRF stay is whether the patient received, and could be expected to benefit from, ''intensive rehabilitation services.'' Please refer to section 110 of the Medicare Benefit Policy Manual, once the revisions that we anticipate issuing on January 1, 2010 have been published, for more specific guidance on what type of information to include when documenting an individualized overall plan of care. Although the intensity of rehabilitation services can be reflected in various ways, the generally-accepted standard by which the intensity of these services is typically demonstrated in IRFs is by the provision of intensive therapies at least 3 hours per day at least 5 days per week. However, we do not intend for this to be the only way such intensity can be demonstrated (that is, we do not intend for this measure to be used as a ''rule of thumb'' for denying an IRF claim). Rather, we suggest that this is one generally accepted way of demonstrating the intensity of services provided in an IRF.

We agree with several of the commenters that the intensity of therapy provided in IRFs could also be demonstrated by the provision of 15 hours of therapy per week (that is, in a 7-consecutive day period starting from the date of admission). For example, if a hypothetical IRF patient was admitted to an IRF for a hip fracture, but was also undergoing chemotherapy for an unrelated issue, the patient might not be able to tolerate therapy on a predictable basis due to the chemotherapy. Thus, this hypothetical patient might be more effectively served by the provision of 4 hours of therapy 3 days per week and 1½ hours of therapy on 2 (or more) other days per week in order to accommodate his or her chemotherapy schedule. Thus, IRFs may also demonstrate a patient's need for intensive rehabilitation therapy services by showing that the patient required and could reasonably be expected to benefit from at least 15 hours of therapy per week (defined as a 7 consecutive day period starting from the date of admission), as long as the reasons for the patient's periodic need for this program of intensive rehabilitation is well-documented in the patient's medical record and the overall amount of therapy is ''intensive'' and can reasonably be expected to benefit the patient. We will monitor the appropriateness of instances where IRFs demonstrate the required level of intensity in this way.

In addition, we note that we will provide guidance in our manuals on additional instances in which we might find that the patient is receiving intensive rehabilitation therapy services despite not receiving the generally expected intensity of therapy services for a brief period of time.

Comment: Several commenters suggested that we include other services, such as recreational therapy, music therapy, respiratory therapy, psychology, and neuropsychology, on the list of therapy services that IRFs must provide, as needed, under § 412.23(b)(4) and § 412.29(c). These commenters also suggested that we specify in the new requirements whether ''other rehabilitative services,'' such as recreational therapy, music therapy, or respiratory therapy, can be used to meet the intensity of therapy requirements, if they are medical necessary and ordered by a physician.

Response: While we believe that IRFs should provide, as needed, psychological and neuropsychological services to IRF patients, these services are separately billable under Medicare Part B, as described in § 411.15(m)(3)(i) and § 411.15(m)(3)(v), and are not included in the IRF PPS payment. Thus, while we would expect the IRF to provide appropriate medical oversight of any medical or psychiatric problem that is present on admission or develops during the stay (in accordance with the overall hospital Conditions of Participation at § 482.12(c)(1)(i), (c)(1)(vi), and (c)(4)), psychological and neuropsychological services furnished pursuant to this responsibility would not be considered part of the required intensity of therapy services that Medicare pays for under the Part A benefit that includes payment for IRF PPS services.

Further, we do not believe that it is appropriate to mandate that all IRFs provide recreational therapy, music therapy, or respiratory therapy services to all IRF patients, as such services may be beneficial to some, but not all, patients as an *adjunct* to other, primary types of therapy services provided in an IRF (physical therapy, occupational therapy, speech-language pathology, and prosthetics/orthotics therapy). However, we do not believe that they should replace the provision of these four core skilled therapy services. Thus, we believe that it should be left to each individual IRF to determine whether offering recreational therapy, music therapy, or respiratory therapy is the best way to achieve the desired patient care outcomes. While we are not adding these therapies to the list of required therapy services in IRFs, we do recognize that they are Medicare-covered services in IRFs if the medical necessity is well documented by the rehabilitation physician in the medical record and is ordered by the rehabilitation physician as part of the overall plan of care for the patient. However, consistent with our long-standing policies and standard practices, these therapy activities are not used to demonstrate that a patient has received intensive therapy services.