Determination and Documentation of Medical Necessity in an Inpatient Rehabilitation Facility Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Determination and Documentation of Medical Necessity in an Inpatient Rehabilitation Facility		
MNG #: 085	☒ **SCO** ☒ **One Care** ☒ **MA Medicare Premier** ☒ **MA Medicare Value** ☒ **RI Medicare Preferred** ☒ **RI Medicare Value** ☒ **RI Medicare Maximum**	**Prior Authorization Needed?** ☒**Yes (always required)** ☐**Yes (only in certain situations. See this MNG for details)** ☐ **No**
Clinical: ☒	**Operational:** ☐	**Informational:** ☐
Benefit Type: ☒ **Medicare** ☐ **Medicaid**	**Approval Date:** 10/14/2021; 1/11/2024	**Effective Date:** 2/06/2022; 1/11/2024
Last Revised Date: 5/30/2022; 01/11/2024	**Next Annual Review Date:** 10/14/2022; 5/30/2023; 01/11/2025	**Retire Date:**

OVERVIEW:

Inpatient Rehabilitation Facility:

Inpatient rehabilitation hospitals and rehabilitation units of acute-care hospitals, collectively known as Inpatient Rehabilitation Facilities (IRFs), provide intensive rehabilitation therapy in a resource-intensive inpatient hospital environment for patients who, because of the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care (the Medicare Benefit Policy Manual (the Manual), Pub. No. 100-02, chapter 1, § 110). The goal-oriented rehabilitative services require the skills of a rehabilitation physician with specialized training and experience in rehabilitative services, a registered nurse with specialized training and experience in rehabilitation, a social worker or case manager (or both), and a licensed physical, speech/language and occupational therapists to safely and effectively furnish a recognized therapy service whose goal is improvement of an impairment or functional limitation for patients that are admitted to an Acute Rehabilitation Hospital.

Interdisciplinary services are those provided by a treatment team in which all members participate in a coordinated effort to benefit the patient and the patient's significant others and caregivers. Interdisciplinary services, by definition, cannot be provided by only one discipline. Though individual members of the interdisciplinary teamwork within their own scopes of practice, each professional is also expected to coordinate with team members of other specialties, as well as with the patient and the patient's significant others and caregivers. The purpose of the interdisciplinary team is to foster frequent, structured, and documented communication among disciplines to establish, prioritize, and achieve treatment goals. The interdisciplinary team must be led by a rehabilitation physician, remotely or in person, and meet weekly at minimum.

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DEFINITIONS:

IRF – Inpatient Rehabilitation Facility - IRFs are free standing rehabilitation hospitals and rehabilitation units in acute care hospitals.

MD – Medical Doctor

NPP- Non-physician practitioner (physician assistants, nurse practitioners, clinical nurse specialists)

RN – Registered Nurse

SW – Social Worker

CM – Case Manager

PT- Physical Therapy

OT- Occupational Therapy

SLP – Speech Language Pathologist

DECISION GUIDELINES:

Clinical Coverage Criteria:

Commonwealth Care Alliance (CCA) follows applicable Medicare and Medicaid regulations and uses evidence based InterQual ©criteria, when available, to review prior authorization requests for medical necessity. This Medical Necessity Guideline (MNG) applies to all CCA Products unless a more expansive and applicable CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), or state-specific medical necessity guideline exists.

Inpatient Rehabilitation Facility services are considered reasonable and necessary when there is a reasonable expectation that these criteria are met at the time of admission:

1. The patient can reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program.

2. The patient requires the active and ongoing therapeutic intervention of multiple therapy disciplines (PT, OT, SLP, or prosthetics/orthotics), one of which must be PT or OT.

3. Is sufficiently stable at the time of the IRF admission and is able to actively participate in the intensive rehabilitation therapy program.

4. The patient requires an intensive therapy program; under industry standard, this is usually three (3) hours of combined therapy per day, at least 5 days per week; in certain, well-documented cases, this therapy might consist of at least fifteen (15) hours of therapy within a seven (7) consecutive calendar day period, beginning with day of admission to IRF.

5. The patient requires MD supervision by a rehabilitation physician, defined as a licensed physician with specialized training and experience in IRF. The requirement for MD supervision

means that the rehabilitation physician must complete a face-to-face visit with the patient at least 3 days/week (beginning with the first week) throughout the admission in the IRF to assess the patient both medically and functionally, as well as to modify the course of treatment as needed to maximize the patient's capacity to benefit from the rehabilitation process. In the second, third, fourth, and the weeks thereafter, a non-physician practitioner (NPP) may conduct one of the three required face to face visits per week so long as it is withing the NPP's scope of practice.

6. A comprehensive preadmission screening that meets all the following requirements:
Conducted by a licensed or certified clinician designated by a rehab physician, conducted more than 48 hours immediately preceding the IRF admission will be accepted as long as it is updated within 48 hours immediately following the IRF admission.

Concurrent Reviews:
Occur every 7 days by a CCA Clinician conducting weekly collaboration with facility case manager to discuss current plan of care and discharge planning. This will include review of clinical documentation to determine continued need based on IRF criteria:

The member must require acute inpatient level of care based on the following clinical needs, according to Medicare criteria or evidence based clinical support tools:

- Relatively intense, multi-disciplinary rehabilitation provided by a coordinated team of physical therapists, occupational therapists, speech language pathologists, nurses and/or other professionals supervised by a physician with experience or training in rehabilitation medicine.
    - MD oversight 3x/week, allowing one of the three visits/week to be performed by a NPP, and 24-hour MD availability
    - Daily skilled nursing services
    - Rehabilitation 3 hours of therapy per day at least 5 days per week provided by a minimum of 2 therapies or 15 hours of therapy in 7 consecutive calendar days in well documented cases
- Reasonable and attainable goals
- Ability and willingness to participate in an intensive rehabilitation program.
- Presence of a condition that cannot be handled at a lower level of care

Determination of need:
The authorizing clinician must determine that the member requires rehabilitative services based on the plan of care that was developed by the IRF. The services shall be of such a level of complexity and sophistication, or the condition of the patient shall be such that the services required can only be safely and effectively performed by a qualified clinician, or therapists supervising assistants.

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LIMITATIONS/EXCLUSIONS:

Services that do not require the professional skills of a therapist to perform or supervise are not medically necessary, even if they are performed or supervised by a therapist or physician. Therefore, if a patient's therapy can proceed safely and effectively through a home exercise program, self-management program, restorative nursing program or caregiver assisted program, payment cannot be made for therapy services.

- If at any point in the treatment it is determined that the treatment becomes repetitive and does not require the unique skills of a therapist, the services are non-covered.

- If a patient's limited ability to comprehend instructions, follow directions, or remember skills that are necessary to achieve an increase in function, is so severe as to make functional improvement very unlikely, rehabilitative therapy is not required, and therefore, is not covered. However, limited services in these circumstances may be covered with supportive documentation if the skills of a therapist are required to establish and teach a caregiver a safety or maintenance program.

- This does not apply to the limited situations where rehabilitative therapy is reasonable and achieving meaningful goals is appropriate, even when a patient does not have the ability to comprehend instructions, follow directions or remember skills. Examples include sitting and standing balance activities that help a patient recover the ability to sit upright in a seat or wheelchair, or safely transfer from the wheelchair to a toilet.

- This does not apply to patients experiencing an unexpected clinical event during their IRF admission which limits the patient from participating in the intensive rehabilitation program for a limited period of time, not to exceed 3 consecutive days.
    - Examples may include extensive diagnostic tests off premises, prolonged intravenous infusion of chemotherapy or blood products, bed rest due to signs of deep vein thrombosis, exhaustion due to recent ambulance transportation, surgical procedure, etc.
    - The specific reasons for the break in the provision of therapy services should be documented in the patient's IRF medical record and should not affect the determination of the medical necessity of the IRF admission.

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AUTHORIZATION:
The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not signify that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. This Medical Necessity Guideline is subject to all applicable Plan Policies and Guidelines, including requirements for prior authorization and other requirements in Provider's agreement with the Plan (including complying with Plan's Provider Manual specifications).

Prior authorizations are required for all Inpatient Rehabilitation Facility admissions. Authorization decisions require documentation of an in-person assessment of the member by a licensed physical therapist, speech/language pathologist, or occupational therapist; the documentation must show why rehabilitative services are needed, what goals are to be achieved, and an approximate timeframe in which the goals can be expected to be achieved. (Note: the time indicated in the assessment shall not be considered a limitation; it will, however, guide when additional information may be requested to document the need for continued coverage).

RELATED REFERENCES:

1. CMS Internet-Only Manual, Medicare Benefit Policy Manual, Chapter 15, §110.2 - Inpatient Rehabilitation Facility Medical Necessity https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c01.pdf
2. Title 42 Code of Federal Regulations 42 CFR SS412.622(a)(3), (4), (5)

Disclaimer
This Medical Necessity Guideline is not a rigid rule. As with all of CCA's criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity (supporting literature (full text preferred) should be attached to the request), or describing the member's unique clinical circumstances, and describing why this service or supply will be more effective and/or less costly than another service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member's unique clinical circumstances will generally be required.

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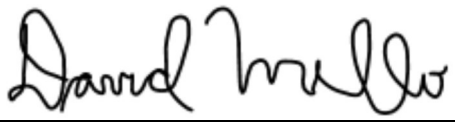
REVISION LOG:

REVISION DATE	DESCRIPTION
1/11/2024	Added language to include use of NPPs for assessments and use of brief exception periods under limitations. Updated references. Updated clinical lead and CMO.
12/31/23	Utilization Management Committee approval
05/30/2022	Template changed to include PA requirements and benefit type. Business owner changed.

APPROVALS:

David Mello	Senior Medical Director, Utilization Review and Medical Policy
CCA Senior Clinical Lead [Print]	**Title [Print]**
	1/11/2024
Signature	**Date**
CCA Senior Operational Lead [Print]	**Title [Print]**
Signature	**Date**
Nazlim Hagmann, MD	Chief Medical Officer
CCA CMO or Designee [Print]	**Title [Print]**
	1/11/2024
Signature	**Date**

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