Acute Inpatient Rehabilitation Hospital Clinical Coverage Criteria

Overview

The acute inpatient rehabilitation hospital benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for patients who, due to 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.

Policy

This Policy applies to the following Fallon Health products:
☒ Medicare Advantage (Fallon Medicare Plus, Fallon Medicare Plus Central)
☒ MassHealth ACO
☒ NaviCare HMO SNP
☒ NaviCare SCO
☒ PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)
☒ Community Care

Fallon Health requires prior authorization for admission to acute inpatient rehabilitation hospitals and continued stay is subject to review.

Medicare Advantage (Fallon Medicare Plus, Fallon Medicare Plus Central)
Fallon Health complies with CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations for Medicare Advantage members. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health may create internal coverage criteria under specific circumstances described at § 422.101(b)(6)(i) and (ii).

Medicare statutes do not have coverage criteria for inpatient rehabilitation hospital services. Medicare regulations at 42 Code of Federal Regulations (CFR) § 412.622 (a)(3), (4), and (5) have coverage criteria for inpatient rehabilitation hospital services. In order for an inpatient rehabilitation hospital service to be considered reasonable and necessary under section 1862(a)(1) of the Act, there must be a reasonable expectation that the patient meets all of the requirements in § 412.622 (a)(3), (4), and (5), at the time of the patient's admission to the inpatient rehabilitation hospital. There are no Medicare NCDs or LCDs for acute inpatient rehabilitation hospital services (Medicare Coverage Database search 05/22/2024).

Coverage criteria for inpatient rehabilitation hospital services are fully established by Medicare, therefore Fallon Health Clinical Coverage Criteria are not applicable.

Inpatient rehabilitation hospital services may be provided by an inpatient rehabilitation hospital or an inpatient rehabilitation unit of an acute inpatient hospital that meets requirements specified in 42 CFR §§ 412.25 and 412.29.

Inpatient rehabilitation facility services will be considered reasonable and necessary (medically necessary) when the plan member meets requirements in 42 CFR §§ 412.622 (a)(3), (4), and (5), as interpreted in the Medicare Benefit Policy Manual, Chapter 1, Section 110 - Inpatient Rehabilitation Facility (IRF) Services. This is true regardless of whether the plan member is treated in the inpatient

rehabilitation hospital for one or more of the thirteen medical conditions listed in 42 CFR § 412.29(b)(2) or not.

Fallon Health makes coverage determinations for inpatient rehabilitation services based on an assessment of each plan member's individual care needs.

Link to: **Medicare Benefit Policy Manual, Chapter 1- Inpatient Hospital Services Covered Under Part A**

Relevant sections include:
110 - Inpatient Rehabilitation Facility (IRF) Services
110.1 - Documentation Requirements
110.1.1 - Required Preadmission Screening
110.1.3 - Required Individualized Overall Plan of Care
110.1.4 - Required Admission Orders
110.1.5 - Required Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI)
110.2 - Inpatient Rehabilitation Facility Medical Necessity Criteria
110.2.1 - Multiple Therapy Disciplines
110.2.2 - Intensive Level of Rehabilitation Services
110.2.3 - Ability to Actively Participate in Intensive Rehabilitation Therapy Program
110.2.4 - Physician Supervision
110.2.5 - Interdisciplinary Team Approach to the Delivery of Care
110.3 - Definition of Measurable Improvement

The inpatient rehabilitation benefit is not to be used as an alternative to completion of the full course of treatment in the referring hospital. A patient who has not yet completed the full course of treatment in the referring hospital is expected to remain in the referring hospital, with appropriate rehabilitative treatment provided, until such time as the patient has completed the full course of treatment. Though medical management can be performed in an inpatient rehabilitation facility, patients must be able to actively participate in and benefit from the intensive rehabilitation therapy program provided in inpatient rehabilitation facilities in order for an inpatient rehabilitation facility claim to be considered reasonable and necessary, in accordance with 42 CFR § 412.622(a)(3)(ii). Therefore, patients who are not able to actively participate in and benefit from the intensive rehabilitation therapy services because they are still completing their course of treatment in the referring hospital should remain in the referring hospital until they are able to do so.

MassHealth ACO
Fallon Health follows Medical Necessity Guidelines published by MassHealth when making medical necessity determinations for MassHealth members. In the absence of Medical Necessity Guidelines published by MassHealth, Fallon Health may create clinical coverage criteria in accordance with the definition of Medical Necessity in 130 CMR 450.204.

MassHealth regulations at **130 CMR 435.410** have level of care criteria for Rehabilitation Hospitals, therefore Fallon Health Clinical Coverage Criteria are not applicable.

Massachusetts licenses hospitals as acute or non-acute under regulations at 105 CMR 130.000. Nonacute hospitals include Chronic Care Hospitals, Rehabilitation Hospitals, Specialty Care Hospitals and others. Program regulations at 130 CMR 435.000 define a Rehabilitation Hospitals as a facility, or a unit within a facility, devoted to the provision of comprehensive services to patients whose handicaps are primarily physical, coordinated with efforts to minimize the patient's mental, social, and vocational disadvantages. The course of treatment is limited to the period in which the member continues to make progress toward his or her treatment goal, as described in the member’s service plan.

Rehabilitation Hospitals consist of Encompass Health of Braintree, Fairlawn Rehab Hospital, Vibra Hospital of Southeastern Massachusetts, Encompass Health Rehab Hospital of New England, Spaulding

Hospital-Cape Cod, Vibra Hospital of Western Massachusetts, Spaulding Rehabilitation Hospital-Boston, Whittier Rehabilitation Hospital-Bradford, and Whittier Rehabilitation Hospital-Westborough. Franciscan Hospital for Children provides both pediatric chronic care and rehabilitation services.

435.410: Level-of-Care Criteria for Rehabilitation Hospitals
(A) Introduction. A member is considered appropriate for rehabilitation hospital placement only when a medical need exists for an intensive rehabilitation program that includes a multidisciplinary approach to improve the member's ability to function to his or her maximum potential. Factors must be present in the member's condition that indicate the potential for functional movement or freedom from pain. A member who requires therapy solely to maintain function is not considered an appropriate rehabilitation hospital patient.

(B) Level-of-Care Criteria. The Medicare rehabilitation hospital level-of-care criteria and the criteria below are used by the Division or its agent to determine the medical necessity of rehabilitation hospital placement. The hospital must provide a rehabilitation program that:
(1) includes specialized skilled nursing services, physical therapy, occupational therapy, and any other services that are necessary for the rehabilitative program (such as speech therapy, prosthetic, or orthotic services);
(2) is organized and directed by a physician who is board-certified in rehabilitation medicine; and
(3) is designed to achieve specified goals within a given time frame.

(C) Team Conferences. The rehabilitation hospital must conduct team conferences for each member. The first team conference must occur within seven calendar days of the member's admission; successive team conferences must occur at least every 14 calendar days thereafter. All team members must be present during the team conferences. These conferences must assess the member's progress and rehabilitation goals, and adjust them when necessary, or terminate the rehabilitation program when the expected outcome is reached. A record must be maintained of:
(1) each team member's goals and progress notes from each conference;
(2) all decisions reached during each team conference; and
(3) the reason for any lack of progress on the part of the member in reaching specific goals.

NaviCare HMO SNP, NaviCare SCO
For plan members enrolled in NaviCare, Fallon Health first follow’s CMS’s national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan’s service area, and applicable Medicare statutes and regulations when making medical necessity determinations.

When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, or if the NaviCare member does not meet coverage criteria in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health then follows Medical Necessity Guidelines published by MassHealth when making necessity determinations for NaviCare members.

PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)
Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed care, all care and services provided to PACE plan members must be authorized by the interdisciplinary team.

Fallon Health Clinical Coverage Criteria

Coverage criteria for Acute Inpatient Rehabilitation Hospitals are fully established by Medicare for Medicare Advantage members and by MassHealth for MassHealth ACO members, therefore, Fallon Health Clinical Coverage Criteria apply to Community Care members only.
Fallon Health follows Medicare criteria for inpatient rehabilitation facility stays, with clarifications based on evidence-based medicine.

1. The member must require the active and ongoing therapeutic intervention of multiple therapy disciplines (physical therapy, occupational therapy, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy.
2. The member must require an intensive rehabilitation therapy program. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least 3 hours of therapy per day at least 5 days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least 15 hours of intensive rehabilitation therapy within a 7 consecutive calendar day period, beginning with the date of admission to the inpatient rehabilitation facility.
3. The member must reasonably be expected to actively participate in, and benefit significantly from, the intensive rehabilitation therapy program at the time of admission to the inpatient rehabilitation facility. The member can only be expected to benefit significantly from the intensive rehabilitation therapy program if the member's condition and functional status are such that the member can reasonably be expected to make measurable improvement (that will be of practical value to improve the member's functional capacity or adaptation to impairments) as a result of the rehabilitation treatment, and if such improvement can be expected to be made within a prescribed period of time. The member need not be expected to achieve complete independence in the domain of self-care nor be expected to return to their prior level of functioning in order to meet this standard.
4. The member must require physician supervision by a rehabilitation physician, defined as a licensed physician who is determined by the inpatient rehabilitation facility to have specialized training and experience in inpatient rehabilitation. The requirement for medical supervision means that the rehabilitation physician must conduct face-to-face visits with the member at least 3 days per week throughout the member's stay in the IRF to assess the member both medically and functionally, as well as to modify the course of treatment as needed to maximize the member's capacity to benefit from the rehabilitation process. Beginning with the second week of admission to the IRF, a non-physician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may conduct 1 of the 3 required face-to-face visits with the member per week, provided that such duties are within the non-physician practitioner's scope of practice under applicable state law. In the first week of the member's IRF stay, the rehabilitation physician is required to visit the member a minimum of three times to ensure that the member's plan of care is fully established and optimized to the member's care needs in the IRF. For the second, third, fourth weeks of the stay, and beyond, Fallon Health will continue to require members in an IRF to receive a minimum of three rehabilitation physician visits per week but will allow non-physician practitioners to independently conduct one of these three minimum require visits per week.
5. The member must require an intensive and coordinated interdisciplinary approach to providing rehabilitation.

A member can only be expected to benefit significantly from an intensive rehabilitation therapy program provided in an inpatient rehabilitation facility, if the member's inpatient rehabilitation facility medical record indicates a reasonable expectation that a measurable, practical improvement in the member's functional condition can be accomplished within a predetermined and reasonable period of time.

Further, the inpatient rehabilitation facility medical record must also demonstrate that the member is making functional improvements that are ongoing and sustainable, as well as of practical value, measured against their condition at the start of treatment.

As a measurable improvement, the Functional Independence Measure (FIM) score is expected to improve by 2 each day, or 14 per week.[1] The range is 18 to 126 with 18 scores of 1 to 7, and Total FIM of >=78 is usually able to be discharged to the community and <=77 was institutional.

[1] The Functional Independence Measure (FIM), developed by Uniform Data System for Medical Rehabilitation, is a widely accepted functional assessment measure used during inpatient rehabilitation. For additional information visit: https://www.udsmr.org/about-us.

Evidence based literature does not support that patients achieve better outcomes after receiving rehabilitation in acute inpatient rehabilitation hospitals compared to other settings for all diagnoses.

Diagnoses that are shown to do better include:
- Acute stroke or traumatic brain injury(TBI) or spinal cord injury(SCI) with residual deficits needing moderate assistance in activities of daily living(ADLs)
- 2 or more limbs which underwent either amputation or joint replacement or fractures; or single joint replacement or amputation for BMI>=50 or age>=85
- Severe burns (about 20% TBSA)
- New onset Guillain Barré which required mechanical ventilation (Meythaler et al., 1997)
- Parkinson's Disease, Hoehn and Yahr stage III and IV, with FIM score below 50 (Ellis et al., 2008)

Diagnoses which are not supported by evidence based medicine
- Hip fracture (Kumar et al., 2018)
- Single joint replacement (Buhagiar et al., 2017, Padgett et al., 2018)
- Multiple sclerosis (Gaber et al., 2012)
- Amyotrophic lateral sclerosis (ALS) (Majmudar et al., 2014)
- Rheumatoid arthritis (Schlademann et al., 2007)

Exclusions

- Acute inpatient rehabilitation that does not meet the above criteria.

Summary of Evidence

N/A

Analysis of Evidence (Rational for Determination)

N/A

References

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Policy history

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Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans.