Acute Inpatient Rehabilitation Facility
Clinical Coverage Criteria

Overview

Acute Inpatient Rehabilitation facilities provide intensive rehabilitation services for those with a complex need for medical management, nursing, and multiple therapy disciplines (PT, OT, etc.). While this rehabilitation is overseen by a physician, the services are coordinated and rendered by a multi-disciplinary team.

For admission and continued stay it is expected the member is able to fully participate and benefit from this approach to care.

Policy

This Policy applies to the following Fallon Health products:

☒ Commercial
☒ Medicare Advantage
☒ MassHealth ACO
☒ NaviCare
☒ PACE

Fallon Health uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations for Medicare Advantage, NaviCare and PACE plan members. National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and guidance in the Medicare manuals are the basis for coverage determinations. When there is no NCD, LCD or manual guidance, Fallon Health Clinical Coverage Criteria are used for coverage determinations.

For Medicare Advantage, NaviCare and PACE plan members, Inpatient Rehabilitation Facility (IRF) Services will be considered reasonable and necessary when the plan member meets all of the 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. Fallon Health makes coverage determinations for IRF services based on an assessment of each plan member's individual care needs.

For a complete list of IRF clarifications, refer to: Clarifications for IRF Coverage Requirements.

Prior authorization is required.

Acute inpatient Rehabilitation Facility criteria for commercial and MassHealth plan members

Fallon Health uses CMS criteria for inpatient rehabilitation facility (IRF) 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 generally require an intensive rehabilitation therapy program, generally consisting of at least 15 hours of therapy per week.

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 IRF. 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 with 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.
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 IRF, if the member's IRF 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 IRF 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 measureable improvement, the 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.

Medicare requires that only 60% of acute patients admitted to Inpatient Rehab have one of the 13 diagnoses, but evidence based literature does not support that only acute inpatient rehabilitation are able to lead to the same outcome as other settings.

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[2]

[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.

[2] Meythaler et al., 1997

- Parkinson's Disease, Hoehn and Yahr stage III and IV, with FIM score below 50[3]

Diagnoses which are not supported by evidence based medicine

- Hip fracture[4]
- Single joint replacement[5,6]
- Multiple sclerosis[7]
- Amyotrophic lateral sclerosis (ALS)[8]
- Rheumatoid arthritis[9]

Please note these services are not part of the per diem and may require separate authorization:

- Ambulance transportation for services not related directly to the plan of care (Please see Fallon Health's Transportation Services Payment Policy for further rules)
- Custom orthotics or prosthetics
- Professional charges for physician services
- Radiation/Chemotherapy

Exclusions

- Acute Inpatient Rehabilitation that does not meet the above criteria

References

1. Medicare Benefit Policy Manual. Chapter 1 - Inpatient Hospital Services Covered Under Part A, Section 110 - Inpatient Rehabilitation Facility (IRF) Services (Rev. 112, Issued: 10-23-09, Effective: 01-01-10, Implementation: 01-04-10).
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7. Safer VB, Koseoglu BF. Timing of inpatient rehabilitation initiation in stroke patients: factors influencing early admission. *J Phys Ther Sci*. 2015 Jun;27(6):1913-7.
8. McLafferty FS, Barmparas G, Ortega A, et. al. Predictors of improved functional outcome following inpatient rehabilitation for patients with traumatic brain injury. *NeuroRehabilitation*. 2016 Jul 15;39(3):423-30.

[3] Ellis et al., 2008
[4] Kumar et al., 2018
[5] Buhagiar et al., 2017
[6] Padgett et al., 2018
[7] Gaber et al., 2012
[8] Majmudar et al., 2014
[9] Schlademann et al., 2007

9. Meythaler JM, DeVivo MJ, Braswell WC. Rehabilitation Outcomes of Patients Who Have Developed Guillain-Barré Syndrome. *Am J Phys Med Rehabil.* Sep-Oct 1997;76(5):411-9.
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12. Kumar A, Rahman, M, Trivedi A, et al. Comparing post-acute rehabilitation use, length of stay, and outcomes experienced by Medicare fee-for-service and Medicare Advantage beneficiaries with hip fracture in the United States: A secondary analysis of administrative data. *PLoS Med*. 2018 Jun 26;15(6):e1002592.
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14. Gaber TA, Oo WW, Gautam V, Smith L. Outcomes of Inpatient Rehabilitation of Patients with Multiple Sclerosis. *Neurorehabilitation.* 2012;30(2):97-100.
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16. Schlademann S, Huppe A, Raspe H. Results of a Randomised Controlled Trial on the Acceptance and the Outcomes of a Counselling on Medical Inpatient Rehabilitation in Gainfully Employed Members of Statutory Health Insurances with Rheumatoid Arthritis. *Gesundheitswesen.* 2007 Jun;69(6):325-35.

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. For Medicare and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this policy.