

**Attachment**

**Hospital Services: Inpatient Intensive Physical Rehabilitation Services**

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## 1 General Information

This attachment is designed to be used in conjunction with other sections of the Utah Medicaid Provider Manual, such as *Hospital Services and Section I: General Information of the Utah Medicaid Provider Manual (Section I: General Information)*.

The information in this manual represents available services when medically necessary. Services may be more limited or may be expanded if the proposed services are medically appropriate and are more cost effective than alternative services.

### 1-1 General Policy

All inpatient rehabilitation services require prior authorization (PA) from Medicaid for reimbursement of services. This attachment to the Hospital Services Manual specifies the requirements for inpatient intensive physical rehabilitation services available for clients who meet the level of care criteria for admission to a distinct part rehabilitation unit of an acute-care general hospital or licensed rehabilitation specialty hospital.

### 1-2 Definitions

Definitions of terms used in other Medicaid programs are available in *Section I: General Information of the Utah Medicaid Provider Manual (Section I: General Information)*. Definitions specific to the content of this manual are provided below.

**Individualized treatment plan:** A coordinated, multidisciplinary plan of care developed by a rehabilitation treatment team in consultation with the patient, spouse, parents, legal guardian, or others into whose care the patient may be released.

**Inpatient hospital intensive physical rehabilitation:** An intense program of physical rehabilitation provided in a distinct part rehabilitation unit of an acute-care general hospital or specialty rehabilitation hospital by a multidisciplinary, coordinated team and for the purpose of upgrading a patient's ability to function.

**Multidisciplinary treatment team:** A group of professionals responsible for and involved in a patient's care, consisting of a physician, a rehabilitation nurse, and a therapist, and optionally one or more additional physicians, physiatrists, rehabilitation nurses, social workers, psychologists, or therapists.

**Case manager:** An individual assigned to assume responsibility for implementation of a patient's individualized treatment plan to ensure that the patient is adequately oriented to the rehabilitation program; ensure the patient's treatment proceeds in an orderly, purposeful, and goal-directed manner; ensure there is program response to the needs and preferences of the patient; promote participation of the patient on an ongoing basis in discussion of plans, goals, status, etc.; consistently participate in multidisciplinary team conferences concerning the patient; and ensure that the discharge plan and arrangements for appropriate follow-up and supportive services are properly made.

### 1-3 Abbreviations

Abbreviations used in the attachment.

<b>FIM</b>	Functional Independent Modifier, a measurement tool
<b>ASIA</b>	American Spinal Injury Association Classification Score, a measurement tool
<b>RANCHO</b>	Rancho Los Amigos Scales of Cognition, a measurement tool

## 2 Program Coverage

Inpatient intensive physical rehabilitation services are covered Medicaid services for acute conditions from birth through any age, require prior authorization, and are available one time per event. EPSDT eligible members with chronic conditions may be considered for age appropriate developmental training. All services are subject to post payment review by the Office of Inspector General (OIG).

Inpatient intensive physical rehabilitation services are intended to provide the therapy necessary to allow the patient to function without avoidable follow-up outpatient therapy. Therefore, the maximum therapy service the patient could receive under the diagnosis related group (DRG) should be provided. Outpatient therapy services requested following inpatient intensive physical rehabilitation services in which the maximum therapy services were not provided, and those services could have been appropriately provided in the inpatient setting, will not be approved without the appropriate committee review.

## 3 Non-Covered Services and Limitations

Rehabilitation services are non-covered when

- The patient's condition and prognosis meets the requirements of placement in a long-term facility, skilled nursing facility, or outpatient rehabilitation service.
- The admission is for deconditioning (e.g., cardiac or pulmonary rehabilitation).

## 4 Prior Authorization

The PA request for inpatient intensive physical rehabilitation services must be submitted within standard timely filing requirements, using the current version of the *Request for Prior Authorization Form*. PA reviews only serve to determine appropriate DRG assignment. Post payment review of a claim by the OIG serves to determine clinical appropriateness of admission and stay.

Failure to obtain prior authorization may result in payment denial. General prior authorization information is provided in the provider manual, *Section I: General Information*.

Medicaid does not process PA requests for services to be provided to a Medicaid client enrolled in an accountable care organization (ACO) when the services are included in the ACO's contract. Providers requesting PA for services to a client enrolled in an ACO shall be instructed to refer such requests to the appropriate ACO for review.

#### 4-1 Notice of Rights

Medicaid gives advance notice, in accordance with State and Federal regulations, when payment is not approved for services for which prior authorization was requested. The notice specifies, the service(s) and reason(s) for which the authorization was not granted, the regulations or rules which apply, and the appeal rights of the provider.

The physician or hospital may not charge the patient for services that are denied for any of the following:

- The provider failed to advise the patient that the services were not a covered Medicaid benefit,
- The provider failed to follow prior authorization procedures, or
- Payment by Medicaid was denied.

The provider may charge the patient for services that are not covered by Medicaid only as allowed in the provider manual, *Section I: General Information, Exceptions to Prohibition on Billing Patients*.

### 5 Multidisciplinary Treatment Team

The multidiscipline treatment team may consist of:

- A rehabilitation physician with specialized training and experience in rehabilitation services;
- A registered nurse with specialized training or experience in rehabilitation;
- A social worker or a case manager (or both); and
- A licensed or certified therapist from each therapy discipline involved in treating the patient.

Each team member must have current knowledge of the patient as documented in the medical record at the inpatient intensive physical rehabilitation hospital. The team is led by a rehabilitation physician who is responsible for making the final decisions regarding the patient's treatment in the inpatient intensive physical rehabilitation hospital.

Within five days of the patient's admission to the facility the following should be complete and documented in the patients' medical record: the team evaluation, an estimated length of stay, and initiation of appropriate discharge planning, including home care assessment.

### 6 Medical Necessity Documentation

The clinical record must be maintained on file in accordance with any federal or state law or state administrative rule, and made available for state or federal review, upon request. Based on CMS and other documentation guidelines, the clinical record of a patient admitted to an inpatient intensive physical rehabilitation hospital should support the admission as reasonable and necessary. The following items and the information contained in the Chapter 7 tables, should help support the admission; however, providers should adhere to all applicable standards in preparing medical documentation:

1. If it is the first admission for this medical event.
2. Appropriate standardized measurement tool scores, including an audiology record for admissions that include speech-language pathology services.

3. The patient requires rehabilitation evaluation and management services of an intensity, frequency, and duration that qualify the patient for inpatient rehabilitation, based on the FIM score or Primary Children's Medical Center score (for EPSDT eligible patients), and other appropriate measurement tools (e.g. ASIA score, Rancho score, Disability Rating Scale (DRS), Walking Index for Spinal Cord Injury (WISCI), Agitated Behavior Scale (ABS) or other equivalent standardized measurement tool scores.)
4. The patient is medically/surgically stable and requires 24-hour nursing care or supervision by a registered nurse with specialized training in rehabilitation.
5. The patient has a reasonable expectation of improvement in activities of daily living appropriate for chronological age and development that will be of significant functional improvement when measured against the patient's documented condition at the time of the initial evaluation.
6. The patient is mentally and physically ready to learn adaptive techniques, transfer skills, and equipment use appropriate for the level of injury.
7. The patient's physical, cognitive, and sensory capacity allows active and ongoing participation in intense, multiple therapy disciplines (physical, occupational, speech-language pathology, or prosthetics/orthotics), one of which must be physical or occupational therapy, designed to restore function rather than maintain existing function.

The generally-accepted standard by which the intensity of these services is typically demonstrated in a inpatient intensive physical rehabilitation hospital is by the provision of intensive therapies at least 3 hours per day at least 5 days per week. However, this is not the only way that such intensity of services can be demonstrated. Intensity of services may vary. For example, a patient admitted for a hip fracture and also undergoing chemotherapy for an unrelated issue, may have less intense therapy on those days chemotherapy is administered. (Also refer to the CMS Brief Exceptions Policy.)

## 7 Quick Reference for Rehabilitation Services

### Spinal Injury - Paraplegia

DRG	Diagnosis	Disease Specific Documentation
8800	Spinal injury resulting in paraplegia	<p>Patient has paralysis of two limbs or half of the body related to trauma or disease of the spinal cord. May be complicated by:</p> <ul style="list-style-type: none"> <li>• Pressure sores</li> <li>• Urological complications (e.g., UTI, dysreflexia)</li> <li>• Respiratory complications</li> <li>• Contractures</li> <li>• Spinal/skeletal instability</li> </ul>

**Spinal Injury - Quadriplegia**

DRG	Diagnosis	Disease Specific Documentation
8801	Spinal injury resulting in quadriplegia	<p>Patient has paralysis of all four limbs.</p> <p>May be complicated by:</p> <ul style="list-style-type: none"> <li>• Pressure sores</li> <li>• Urological complications (e.g., UTI, dysreflexia)</li> <li>• Respiratory complications</li> <li>• Contractures</li> <li>• Spinal/skeletal instability</li> </ul>

**Traumatic Brain Injury (TBI)**

DRG	Diagnosis	Disease Specific Documentation	Comments
8802	Traumatic Brain injury	<p>The Rancho Classification scale must be in the medical record and must have two or more neurological deficits documented:</p> <ul style="list-style-type: none"> <li>• Dysphagia</li> <li>• Dysphasia</li> <li>• Paralysis</li> <li>• Visual disturbances</li> <li>• Cognitive deficit</li> </ul>	Documentation of well-defined treatment goals for functional improvement. The patient is an evolving Rancho 3 or Rancho 4-6 with behavior management issues.

**Stroke (CVA)**

DRG	Diagnosis	Disease Specific Documentation
8803	Stroke (cardiovascular accident)	<ul style="list-style-type: none"> <li>• Treatment must begin within 60 days after onset of stroke.</li> <li>• Patient has sustained focal neurological deficit.</li> <li>• The rehabilitation service is for a separate focal CVA site than a previous admission.</li> </ul>

**Other Diagnoses**

DRG	Diagnosis	Disease Specific Documentation
8804	<p>Other conditions which may require intensive inpatient rehabilitation program:</p> <p><u>Neurological Defect:</u></p> <ul style="list-style-type: none"> <li>• Amyotrophic lateral sclerosis (ALS)</li> <li>• Guillain-Barre Syndrome</li> <li>• Multiple Sclerosis</li> </ul>	<p>Patient with marked physical impairment secondary to a variety of problems such as trauma, surgery, chronic disease, and malnutrition or a combination of factors that can be expected to improve with a comprehensive physical restoration program.</p> <p>The FIM score or the Primary Children's Medical Center score must be in the record. Other standardized</p>

DRG	Diagnosis	Disease Specific Documentation
	<ul style="list-style-type: none"> <li>• Myelopathy (transverse myelitis infarction)</li> <li>• Myopathy</li> <li>• Parkinson’s Disease</li> </ul> <p><u>Congenital deformity</u> (e.g. following dorsal rhizotomy)</p> <ul style="list-style-type: none"> <li>• Complex fractures (e.g. hip) or fracture with complicating condition</li> <li>• Amputation with complication or multiple amputation</li> <li>• Post neurosurgery of Brain or Spine (e.g. tumor)</li> <li>• Burns</li> <li>• Major multiple</li> <li>• trauma (e.g. fractures, amputation)</li> <li>• Post meningoencephalitis</li> </ul>	<p>measurement tool scores may be required depending on the diagnosis.</p> <p><u>Amputation:</u> The patient must have been mobile prior to the injury. Supportive documentation must substantiate a rehabilitation stay will be beneficial to the patient. The stump must be healed to the point that physical therapy and rehabilitation education can be accomplished.</p> <p><u>Post neurosurgery:</u> Must have complicating medical condition which requires close medical supervision by a physician with resulting muscular skeletal deficit.</p> <p><u>Burns:</u> Disability due to burns involving at least 15% of the body.</p>

## 6 References

Utah Medicaid Provider Manual, Hospital Services

Utah Administrative Code R414-1, Utah Medicaid Program

State Plan Amendment

Attachment 3.1-A, Amount, Duration, and Scope of Medical and Remedial Care and Services Provided to the Categorically Needy

Attachment 4.19-A, Methods and Standards for Establishing Payment Rates - Inpatient Hospital Care

Utah Code

§26-1-5, Rules of department

§26-1-15, Executive director -- Power to accept federal aid

§26-18-6, Federal aid -- Authority of executive director

Social Security Act Sections 1901, 1905(a)(1)

Medicare Benefit Policy Manual, Chapter 1 - Inpatient Hospital Services Covered Under Part A (Rev. 189, 06-27-14)

42 CFR

§412.29(b)(2), Classification criteria for payment under the inpatient rehabilitation facility prospective payment system

§§412.622(a)(3), (4), and (5), Basis of Payment (As interpreted by CMS)

§440.10, Inpatient hospital services, other than services in an institution for mental diseases

§456.80, Individual written plan of care