BlueCross BlueShield of North Carolina

Medicare Part C Medical Coverage Policy

Rehabilitation Therapy- Inpatient

Origination: January 8, 1990
Review Date: November 14, 2023
Next Review: November 2024

****** This policy was implemented in the absence of National Coverage Determinations (NCD) or Local Coverage Determinations (LCD) coverage criteria. This policy applies to all Blue Medicare HMO, Blue Medicare PPO, Blue Medicare Rx members, and members of any third-party Medicare plans supported by Blue Cross NC through administrative or operational services. ******

DESCRIPTION OF PROCEDURE

The inpatient rehabilitation facility (IRF) benefit is designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment for members 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 STATEMENT

Coverage will be provided for inpatient rehabilitation when it is determined to be medically necessary when the medical criteria and guidelines shown below are met.

BENEFIT APPLICATION

Please refer to the member's individual Evidence of Coverage (EOC) for benefit determination. Coverage will be approved according to the EOC limitations if the criteria are met.

Coverage decisions will be made in accordance with:

- The Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs);
- General coverage guidelines included in Original Medicare manuals unless superseded by operational policy letters or regulations; and
- Written coverage decisions of local Medicare carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.

Benefit payments are subject to contractual obligations of the Plan. If there is a conflict between the general policy guidelines contained in the Medical Coverage Policy Manual

and the terms of the member's particular Evidence of Coverage (EOC), the EOC always governs the determination of benefits.

INDICATIONS FOR COVERAGE

The services must be reasonable and necessary (in terms of efficacy, duration, frequency, and amount) for the treatment of the member's condition. It must also be reasonable and necessary due to the member's condition to receive a more coordinated, intensive program of multiple services to furnish the care on an inpatient hospital basis, rather than in a less intensive facility such as a Skilled Nursing Facility (SNF) or on an outpatient basis.

Preauthorization by the Plan is required.

Authorization is appropriate if **each** of the following conditions are met:

1. The member must require the active and ongoing therapeutic intervention of at least two 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. Under current industry standards, this intensive rehabilitation therapy program generally consists of at least three (3) hours of therapy per day at least five (5) days per week. In certain well-documented cases, this intensive rehabilitation therapy program might instead consist of at least fifteen (15) hours of intensive rehabilitation therapy within a seven (7) consecutive day period, beginning with the date of admission to the inpatient rehabilitation facility (IRF).

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 patient need not be expected to achieve complete independence in the domain of self-care nor be expected to return to his or her 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 patient at least three (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.

COVERAGE WILL NOT BE APPROVED FOR THE FOLLOWING INDICATIONS

- When criteria above are not met.

SPECIAL NOTES

- See Summary of Coverage Criteria: "Speech Language Pathology"

- Services cannot be denied because the member could not be expected to achieve complete independence in the domain of self-care, or because the member cannot return to his/her prior level of functioning, but the documentation must include the member's ongoing requirement for an intensive level of service and an inter-disciplinary team approach**.** The record must state the member is making functional improvements that are ongoing and sustainable, as well as have practical value, measured against the members' condition at the start of treatment.

The goal of IRF treatment is to enable the member's safe return to the home or community. Emphasis of therapies would generally shift from member centered services to member-caregiver education, durable medical equipment, or other to prepare the member for a safe discharge.

References:

1. Medicare Benefit Policy Manual; Chapter 1- Inpatient Hospital Services Covered Under Part A (Rev.189, 06/27/14), Section 110, accessed via Medicare Benefit Policy Manual (cms.gov) viewed on October 31, 2023.

Policy Implementation and Update Information:

Revision Date: March 31, 1993; March 23, 1998 (Merger of Outpatient and Inpatient Rehabilitative Services into one policy);
Revision Date: September 1, 2000; December 8, 2004
Revision Date: November 30, 2006: Name changed to "Rehabilitation Therapy- Inpatient" Removed outpatient therapy information since this service does not require medical necessity review. Added clarification under "Limitations" for when coverage will stop. No further criteria changes made.
Revision Date: June 17, 2009: New online policy format; no criteria changes made.
Revision Date: May 27, 2010: Updated to reflect CMS coverage criteria. Removed Medical Director review required.
Revision Date: January 2013, Annual Review; No revisions.
Revision Date: February 2014; Noted CMS clarification of Inpatient Criteria #3 according to CMS Medicare Benefit Policy Manual 110.2 bullet 3.
Revision Date: January 7, 2016, no new CMS guidance, minor revisions to policy for consistency; reference section updated.
Revision Date: January 17, 2018; No CMS updates, Minor Revisions Only.
Revision Date: January 15, 2020; No CMS Updates. Minor Revisions Only.
Revision Date: January 19, 2022; No CMS Updates. Minor Revisions Only.
Revision Date: November 14, 2023; No CMS Updates; Minor Revisions only. Added the following statement to the beginning of policy: "This policy was implemented in the absence of National Coverage Determinations (NCD) or Local Coverage Determinations (LCD) coverage criteria." Statement added to align with the 2024 CMS Final Rule.

Approval Dates:

Medical Coverage Policy Committee: November 15, 2023

Physician Advisory Group/UM Committee: November 14, 2023

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