Inpatient Rehabilitation Facility Services

Medicare Advantage Medical Policy #MNG-004
Original Effective Date: 12/27/2023
Current Effective Date: 01/01/2025

Applies to all products administered or underwritten by the Health Plan, unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Instructions for Use
Inpatient rehabilitation facility (IRF) services are covered when medical criteria for admissions are met. All IRF services must be reasonable and necessary to be covered by the MA plan. Medical necessity determinations will be made in accordance with generally accepted standards of medical practice, taking into account credible scientific evidence published in peer reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of the physicians practicing in relevant clinical areas, and other relevant factors, as they related to the member's clinical circumstances.

The 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.

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. In general, the goal of IRF treatment is to enable the member's safe return to the home or community-based environment upon discharge from the IRF. The member's IRF medical record is expected to indicate both the nature and degree of expected improvement and the expected length of time to achieve the improvement.

Preauthorization by the Plan is required.

When Services May Be Eligible for Coverage
Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- *Benefits are available in the member's contract/certificate, and*
- *Medical necessity criteria and guidelines are met.*

Based on review of available data, the Health Plan may consider authorization to be **eligible for coverage**** if **EACH** of the following conditions are met:

- 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.
- 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 (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 calendar day period, beginning with the date 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 at the time of admission are such that the member can reasonably be expected to make measurable improvement (that will be of practical value to 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.
- 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.
- The member must require an intensive and coordinated interdisciplinary approach to providing rehabilitation. Skilled staff in the IRF program should include: rehabilitation physician, physical/occupational therapist, and speech-language pathologist.

When Services Are Not Covered
Based on review of available data, when criteria above are not met the Health Plan will considers services to be **not covered.****

Rationale/Source
This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to federal regulations, other plan medical policies, and accredited national guidelines.

References
1. Centers for Medicare and Medicaid Services (CMS). Medicare Benefit Policy Manual, CMS Pub. 100-2, Chap 1 - Inpatient Hospital Services Covered Under Part A, Sec. 110.2 - Inpatient Rehabilitation Facility (IRF) Services (Rev. 10892, 08/06/2021, Effective 11/08/2021). Available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/ Downloads/ bp102c01.pdf.
2. Interqual Solution. https://www.changehealthcare.com/clinical-decision-support/interqual.
3. (n.d.). Final Rule 2024. https://public-inspection.federalregister.gov/2023-07115.pdf.
4. (n.d.). Medicare Program MA. https://www.Federalregister.gov/Documents/2023/04/12/2023-07115/Medicare-Program-Contract-Year-2024-Policy-And-Technical-Changes-To-The-Medicare-Advantage-Program.
5. (n.d.). CMS Addendum E. https://www.cms.gov/Files/Document/Mm13031-Hospital- Outpatient-Prospective-Payment-System-January-2023-Update.pdf.

Policy History
Original Effective Date: 12/27/2023
Current Effective Date: 01/01/2025
12/21/2023 New policy created.
12/27/2023 Utilization Management Committee review and approval. New Policy.
10/14/2024 Policy review and revised.

10/15/2024 Utilization Management Committee review and approval. Reference sources updated. No substantive changes made.

***Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "nationally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other relevant factors.

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NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Health Plan recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

Medicare Advantage Members
Established coverage criteria for Medicare Advantage members can be found in Medicare coverage guidelines in statutes, regulations, National Coverage Determinations (NCD)s, and Local Coverage Determinations (LCD)s. To determine if a National or Local Coverage Determination addresses coverage for a specific service, refer to the Medicare Coverage Database at the following link: https://www.cms.gov/medicare-coverage-database/search.aspx. You may wish to review the Guide to the MCD Search here: https://www.cms.gov/medicare-coverage-database/help/mcd-bene-help.aspx.

When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, internal coverage criteria may be developed. This policy is to serve as the summary of evidence, a list of resources and an explanation of the rationale that supports the adoption of this internal coverage criteria.