MEDICAL POLICY	Rehabilitation: Acute Inpatient (Medicare Only)
Effective Date: 2/1/2022  2/1/2022 Medical Officer Date	Medical Policy Number: 514 Medical Policy Committee Approved Date: 12/2021

See Policy CPT/HCPCS CODE section below for any prior authorization requirements

SCOPE:

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as "Company" and collectively as "Companies").

APPLIES TO:

Medicare Only

DOCUMENTATION REQUIREMENTS

The *Medicare Benefit Policy Manual, Chapter 1 – Inpatient Hospital Services Covered Under Part A, §110.1 - Documentation Requirements* provides various subsections to detail all documentation requirements for inpatient rehabilitation facility (IRF) stays. The following list is derived in part from that manual reference, but additional information may be requested if medical necessity cannot be determined with the documentation submitted.

- Initial Admission:
  - Pre-admission screening
  - Post-admission physician evaluation
  - Individualized care plan, which must detail the member's medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRF stay, thereby supporting the medical necessity of the admission;
  - Admission orders
- Continued stay:
  - Records must demonstrate the member's ongoing requirement for an intensive level of rehabilitation services and an inter-disciplinary team approach to care
  - Records must also demonstrate the member is making functional improvements that are ongoing and sustainable, and of practical value, measured against their condition at the start of treatment.
  - The member's response to the services provided during the course of the admission;

MEDICAL POLICY	Rehabilitation: Acute Inpatient (Medicare Only)
Effective Date: 2/1/2022	Medical Policy Number: 514
 2/1/2022	Medical Policy Committee Approved Date: 12/2021
Medical Officer Date	

MEDICARE POLICY CRITERIA

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

Service	Medicare Guidelines
IMPORTANT NOTE: Medicare Guidance for inpatient rehabilitation facility (IRF) services are found in various subsections of the *Medicare Benefit Policy Manual, Chapter 1 – Inpatient Hospital Services Covered Under Part A, §110 Inpatient Rehabilitation Facility (IRF) Services*. See the subsequent rows for more details.	
Initial Admission	§110.2 - Inpatient Rehabilitation Facility Medical Necessity Criteria
Continued Stay	§110.3 - Definition of Measurable Improvement *(See within the 3rd paragraph the documentation required to justify the need for a continued IRF stay)*

POLICY GUIDELINES

The *Medicare Claims Processing Manual, Chapter 3 - Inpatient Hospital Billing, §140.1.1 - Criteria That Must Be Met By Inpatient Rehabilitation Facilities, C. List of Medical Conditions*, provides a list of medical conditions that are frequently associated with requiring intensive rehabilitative services.

However, according to the *Medicare Learning Network (MLN) Article MM6699*, "IRF care is only considered by Medicare to be reasonable and necessary under 1862(a)(1)(A) if the patient meets all of the requirements… interpreted in Chapter 1, Section 110 of the Medicare Benefit Policy Manual… This is true regardless of whether the patient is treated in the IRF for 1 or more of the 13 medical conditions listed in 42 CFR 412.23(b)(2)(iii) or not."[1]

While the CFR cited by MM6699 was the 2007 edition, this list is currently available in the aforementioned Medicare Claims Processing Manual reference §140.1.1 Subsection C and the same medical necessity rationale continues to apply. ***Thus, while this list may be useful in some situations, inclusion of a medical condition on this list does not imply automatic coverage and omission of a***

condition from this list should not result in an automatic denial. All applicable criteria from Section 110 (see Medicare Policy Criteria above) must still be satisfied.

CPT/HCPCS CODES

Medicare Only	
No Prior Authorization Required	
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97140	Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97161	Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome
97162	Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family
97163	Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high

	complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family
97165	Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (eg, physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family
97166	Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family
97167	Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (ie, relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (eg, physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family

97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes
97542	Wheelchair management (eg, assessment, fitting, training), each 15 minutes
Unlisted Codes All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then **prior-authorization is required.**	
97139	Unlisted therapeutic procedure (specify)

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

REFERENCES

1. Medicare Learning Network (MLN) Matters® Number: MM6699 Revised; Available at: https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/MM6699.pdf [Last Cited 10/29/2021]
2. Fact Sheet #1, Inpatient Rehabilitation Facility Classification Requirements; Available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/downloads/fs1classreq.pdf [Last Cited 10/29/2021] *(See section for "Changes to the List of Medical Conditions Requiring Intensive Rehabilitative Services")*
3. Medicare Inpatient Rehabilitation Facilities web page; Last Modified 03/05/2012; Available at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/InpatientRehab [Last Cited 10/29/2021]
4. 42 CFR 412.29(b)(2); Available at: https://www.law.cornell.edu/cfr/text/42/412.29 [Last Cited 10/29/2021]