Medicare Medical Policy

Rehabilitation: Acute Inpatient

MEDICARE MEDICAL POLICY NUMBER: 514

Effective Date: 1/1/2023

Last Review Date: 12/2022

Next Annual Review: 12/2023

INSTRUCTIONS FOR USE: Company Medicare Medical Policies serve as guidance for the administration of plan benefits and do not constitute medical advice nor a guarantee of coverage. Company Medicare Medical Policies are reviewed annually to guide the coverage or non-coverage decision-making process for services or procedures in accordance with member benefit contracts (otherwise known as Evidence of Coverage or EOCs) and Centers of Medicare and Medicaid Services (CMS) policies, manuals, and other CMS rules and regulations. In the absence of a CMS coverage determination or specific regulation for a requested service, item or procedure, Company policy criteria or applicable utilization management vendor criteria may be applied. These are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. 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.

The Company reserves the right to determine the application of Medicare Medical Policies and make revisions to these policies at any time. Any conflict or variance between the EOC and Company Medical Policy will be resolved in favor of the EOC.

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”).

PRODUCT AND BENEFIT APPLICATION

☒ Medicare Only

MEDICARE COVERAGE CRITERIA

IMPORTANT NOTE: More than one Centers for Medicare and Medicaid Services (CMS) reference may apply to the same health care service, such as when more than one coverage policy is available (e.g., both an NCD and LCD exist). All references listed should be considered for coverage decision-making. The Company uses the most current version of a Medicare reference available at the time of publication; however, these websites are not maintained by the Company, so Medicare references and their corresponding hyperlinks may change at any time. If there is a conflict between the Company Medicare Medical Policy and CMS guidance, the CMS guidance will govern.

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)*

IMPORTANT NOTICE: While some services or items may appear medically indicated for an individual, they may also be a direct exclusion of Medicare or the member's benefit plan. Such excluded services or items by Medicare and member EOCs include, but are not limited to, services or procedures considered to be cosmetic, not medical in nature, or those considered not medically reasonable or necessary under *Title XVIII of the Social Security Act, §1862(a)(1)(A).* If there is uncertainty regarding coverage of a service or item, please review the member EOC or submit a pre-service organization determination request. Note that the Medicare Advance Beneficiary Notice of Noncoverage (ABN) form **cannot** be used for Medicare Advantage members. *(Medicare Advance Written Notices of Non-coverage. MLN006266 May 2021)*

POLICY CROSS REFERENCES

None

The full Company portfolio of Medicare Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

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

BACKGROUND

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.***

REGULATORY STATUS

U.S. FOOD & DRUG ADMINISTRATION (FDA)

While clearance by the Food and Drug Administration (FDA) is a prerequisite for Medicare coverage, the 510(k) premarket clearance process does not in itself establish medical necessity. Medicare payment policy is determined by the interaction of numerous requirements, including but not limited to, the availability of a Medicare benefit category and other statutory requirements, coding and pricing guidelines, as well as national and local coverage determinations and clinical evidence.

BILLING GUIDELINES AND CODING

CPT CODES 0441T AND 64640

The codes 0441T and 64640 are not specific to the procedures and/or indications addressed in this policy.

Category III code 0441T will be considered **not medically necessary** for the therapies addressed in this policy for the treatment of plantar fasciitis and when reported with ICD-10 code M72.2 or other related ICD codes (**Note**: This is in addition to the noncovered indications addressed in the separate *Knee: Genicular Nerve Blocks and Nerve Ablation for Knee Pain (Medicare Only)* policy.)
CPT code 64640 will deny as **not medically necessary** when **not** reported with an ICD-10 code that supports medical necessity for Medicare, as determined by the relevant nerve blockade LCA A52725.

CODES*		
CPT	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)
	97139	Unlisted therapeutic procedure (specify)
	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
HCPCS	None	

***Coding Notes:**

- The code list above is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit. According to Medicare, "presence of a payment amount in the MPFS and the Medicare physician fee schedule database (MPFSDB) does not imply that CMS has determined that the service may be covered by Medicare." The issuance of a CPT or HCPCS code or the provision of a payment or fee amount by Medicare does **not** make a procedure medically reasonable or necessary or a covered benefit by Medicare. *(Medicare Claims Processing Manual, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician's Fee Schedule, A. Physician's Services)*
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.
- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

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 10/25/2022]
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 10/25/2022] *(See section for "Changes to the List of Medical Conditions Requiring Intensive Rehabilitative Services")*
3. Medicare Inpatient Rehabilitation Facilities web page; Last Modified 12/01/2021; Available at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/InpatientRehab [Last Cited 10/25/2022]
4. 42 CFR 412.29(b)(2); Available at: https://www.law.cornell.edu/cfr/text/42/412.29 [Last Cited 10/25/2022]

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
1/2023	Annual review (converted to new format 2/2023)