Acute Inpatient Rehabilitation Payment Policy

Policy

The Plan requires prior authorization for admission to acute inpatient rehabilitation facilities and continued stay is subject to review. The criteria listed below must be met for admission:

1. The member has medically complex issues, a functional impairment, and the ability to participate in an intensive rehabilitation program.
2. The member is able to participate in intensive rehabilitation for at least 3 hours per day for 5 days a week, or at least 15 hours in 7 days. The member must reasonably benefit from this and make measurable improvements in their functional abilities.
3. The member's program must be physician-supervised and requires 3 face to face visits by a physician licensed and with specialized training and expertise in inpatient rehabilitation.
4. The member requires an intensive and coordinated interdisciplinary rehabilitation program. Rehabilitation must be inclusive of multiple therapy disciplines, one of which must be physical or occupational therapy.

Continued Stay (continued stay is concurrently reviewed by the Plan and the need for continued services must be clearly documented in the medical records):

1. As supported in the medical record, the member must be making measurable improvement in functional status within a predetermined and reasonable period of time.
2. The member has a continued need and ability to tolerate intensive rehabilitation defined as at least 3 hours a day for 5 days a week, or at least 15 hours in 7 days.
3. The member cannot safely and effectively be managed in a less restrictive clinical setting.

Definitions

Acute inpatient rehabilitation facilities provide intensive rehabilitation services for those with complex needs for medical management, nursing, and multiple therapy disciplines (PT, OT, etc.). While this rehabilitation is overseen by a physician, the services are coordinated and rendered by a multi-disciplinary team.

For admission and continued stay it is expected that the member is able to fully participate and benefit from this approach to care.

Reimbursement

Acute inpatient rehabilitation facilities are reimbursed at a single all-inclusive (per diem) rate as determined by the contracted rate. Prior authorization is required and notification to the Plan must be made within appropriate timeframes.

The per diem rate is generally considered payment in full for all services provided to the member and includes the following (please note that these are general examples of what is covered in the per diem rate; this list is not necessarily all-inclusive and may be subject to the particular contract with the facility):

- Ambulance transportation directly related to the plan of care
- Bariatric equipment
- Daily nursing care
- Daily therapies (physical, occupational, speech, respiratory, etc.)
- Dialysis
- Discharge planning
- Durable medical equipment (any specialized DME required for patients should be requested via prior authorization):
  - Non-disposable single patient use DME provided as part of an individual member's inpatient rehabilitation care is included in the per diem rate and should be sent home

with the member upon discharge from the facility. This includes (but is not limited to) bed pans, emesis basins, splints, and tens.
    - Non-disposable/multi-patient use DME provided as part of an individual member's inpatient rehabilitation care that is owned or rented by the facility is included in the per diem rate and should not be sent home with the member upon discharge. This includes (but is not limited to) wheelchairs, walkers, and canes.
    - If the Plan purchases any DME on behalf of an individual member receiving care within the facility (either purchased from the facility or from an independent DME provider), those items must be sent home with the patient upon discharge from the facility. These items include but are not limited to: Customized orthotics, prosthetics, adaptive devices, and bariatric equipment.
    - The rehabilitation facility agrees to not delay obtaining authorization and ordering any custom-type device that is medically necessary to promote discharge and rehabilitation of the member. This type of DME must be authorized by the Plan and ordered through a Plan-contracted DME provider.
- Enteral/parenteral nutrition and supplies
- Infusion pumps and services
- Laboratory services
- Medical/surgical supplies and equipment
- Medications
- Non-custom orthotics or prosthetics
- On-site/mobile x-ray
- Private room, when medically indicated
- Semi-private room and board
- Social services
- Wound vacuum

Services Not Included in the Per Diem Rate:
The following services will be reimbursed to the rehabilitation facility separately from the per diem rate and **may require separate authorization** (please note that these are general examples of what is not covered in the per diem rate; this list is not necessarily all inclusive and may be subject to the particular contract with the facility):

- Ambulance transportation for services not directly related to the plan of care (Please see Fallon Health's *Transportation Services Payment Policy* for further details)
- Custom orthotics or prosthetics
- Professional charges for physician services
- Radiation/chemotherapy

Referral/notification/prior authorization requirements

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Policy history

Origination date:	October 1, 2016
Previous revision date(s):	N/A 01/01/2017 - Introduced policy
Connection date & details:	July 2017 – Updated the reimbursement section. July 2018 – Annual Review, no update. July 2019 – Annual Review, no update.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for the Plan. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. The Plan reserves the right to apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.