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Clinical Appropriateness Guidelines

Post-Acute Care (PAC)

Appropriate Use Criteria: Level of Care – Inpatient Rehabilitation Facility (IRF)

Proprietary

Table of Contents

Description and Application of the Guidelines

The Carelon Clinical Appropriateness Guidelines (hereinafter “the Carelon Clinical Appropriateness Guidelines” or the “Guidelines”) are designed to assist providers in making the most appropriate treatment decision for a specific clinical condition for an individual. The Guidelines establish objective and evidence-based criteria for medical necessity determinations, where possible, that can be used in support of the following:

- To establish criteria for when services are medically necessary
- To assist the practitioner as an educational tool
- To encourage standardization of medical practice patterns
- To curtail the performance of inappropriate and/or duplicate services
- To address patient safety concerns
- To enhance the quality of health care
- To promote the most efficient and cost-effective use of services

The Carelon guideline development process complies with applicable accreditation and legal standards, including the requirement that the Guidelines be developed with involvement from appropriate providers with current clinical expertise relevant to the Guidelines under review and be based on the most up-to-date clinical principles and best practices. Resources reviewed include widely used treatment guidelines, randomized controlled trials or prospective cohort studies, and large systematic reviews or meta-analyses. Carelon reviews all of its Guidelines at least annually.

Carelon makes its Guidelines publicly available on its website. Copies of the Guidelines are also available upon oral or written request. Additional details, such as summaries of evidence, a list of the sources of evidence, and an explanation of the rationale that supports the adoption of the Guidelines, are included in each guideline document.

Although the Guidelines are publicly available, Carelon considers the Guidelines to be important, proprietary information of Carelon, which cannot be sold, assigned, leased, licensed, reproduced or distributed without the written consent of Carelon.

Carelon applies objective and evidence-based criteria, and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services. The Carelon Guidelines are just guidelines for the provision of specialty health services. These criteria are designed to guide both providers and reviewers to the most appropriate services based on a patient’s unique circumstances. In all cases, clinical judgment consistent with the standards of good medical practice should be used when applying the Guidelines. Guideline determinations are made based on the information provided at the time of the request. It is expected that medical necessity decisions may change as new information is provided or based on unique aspects of the patient’s condition. The treating clinician has final authority and responsibility for treatment decisions regarding the care of the patient and for justifying and demonstrating the existence of medical necessity for the requested service. The Guidelines are not a substitute for the experience and judgment of a physician or other health care professionals. Any clinician seeking to apply or consult the Guidelines is expected to use independent medical judgment in the context of individual clinical circumstances to determine any patient’s care or treatment.

The Guidelines do not address coverage, benefit or other plan specific issues. Applicable federal and state coverage mandates take precedence over these clinical guidelines, and in the case of reviews for Medicare Advantage Plans, the Guidelines are only applied where there are not fully established CMS criteria. If requested by a health plan, Carelon will review requests based on health plan medical policy/guidelines in lieu of the Carelon Guidelines. Pharmaceuticals, radiotracers, or medical devices used in any of the diagnostic or therapeutic interventions listed in the Guidelines must be FDA approved or conditionally approved for the intended use. However, use of an FDA approved or conditionally approved product does not constitute medical necessity or guarantee reimbursement by the respective health plan.

The Guidelines may also be used by the health plan or by Carelon for purposes of provider education, or to review the medical necessity of services by any provider who has been notified of the need for medical necessity review, due to billing practices or claims that are not consistent with other providers in terms of frequency or some other manner.

General Clinical Guideline

Clinical Appropriateness Framework

Critical to any finding of clinical appropriateness under the guidelines for a specific diagnostic or therapeutic intervention are the following elements:

- Prior to any intervention, it is essential that the clinician confirm the diagnosis or establish its pretest likelihood based on a complete evaluation of the patient. This includes a history and physical examination and, where applicable, a review of relevant laboratory studies, diagnostic testing, and response to prior therapeutic intervention.
- The anticipated benefit of the recommended intervention is likely to outweigh any potential harms, including from delay or decreased access to services that may result (net benefit).
- Widely used treatment guidelines and/or current clinical literature and/or standards of medical practice should support that the recommended intervention offers the greatest net benefit among competing alternatives.
- There exists a reasonable likelihood that the intervention will change management and/or lead to an improved outcome for the patient.

Providers may be required to submit clinical documentation in support of a request for services. Such documentation must a) accurately reflect the clinical situation at the time of the requested service, and b) sufficiently document the ordering provider's clinical intent.

If these elements are not established with respect to a given request, the determination of appropriateness will most likely require a peer-to-peer conversation to understand the individual and unique facts that would justify a finding of clinical appropriateness. During the peer-to-peer conversation, factors such as patient acuity and setting of service may also be taken into account to the extent permitted by law.

Simultaneous Ordering of Multiple Diagnostic or Therapeutic Interventions

Requests for multiple diagnostic or therapeutic interventions at the same time will often require a peer-to-peer conversation to understand the individual circumstances that support the medical necessity of performing all interventions simultaneously. This is based on the fact that appropriateness of additional intervention is often dependent on the outcome of the initial intervention.

Additionally, either of the following may apply:

- Current literature and/or standards of medical practice support that one of the requested diagnostic or therapeutic interventions is more appropriate in the clinical situation presented; or
- One of the diagnostic or therapeutic interventions requested is more likely to improve patient outcomes based on current literature and/or standards of medical practice.

Repeat Diagnostic Intervention

In general, repeated testing of the same anatomic location for the same indication should be limited to evaluation following an intervention, or when there is a change in clinical status such that additional testing is required to determine next steps in management. At times, it may be necessary to repeat a test using different techniques or protocols to clarify a finding or result of the original study.

Repeated testing for the same indication using the same or similar technology may be subject to additional review or require peer-to-peer conversation in the following scenarios:

- Repeated diagnostic testing at the same facility due to technical issues
- Repeated diagnostic testing requested at a different facility due to provider preference or quality concerns

- Repeated diagnostic testing of the same anatomic area based on persistent symptoms with no clinical change, treatment, or intervention since the previous study
- Repeated diagnostic testing of the same anatomic area by different providers for the same member over a short period of time

Repeat Therapeutic Intervention

In general, repeated therapeutic intervention in the same anatomic area is considered appropriate when the prior intervention proved effective or beneficial and the expected duration of relief has lapsed. A repeat intervention requested prior to the expected duration of relief is not appropriate unless it can be confirmed that the prior intervention was never administered. Requests for on-going services may depend on completion of previously authorized services in situations where a patient's response to authorized services is relevant to a determination of clinical appropriateness.

Post-Acute Care – Inpatient Rehabilitation Facility

General Information

Abbreviations

- Activities of Daily Living (ADL)
- Americans with Disabilities Act (ADA)
- Bilevel Positive Airway Pressure Machine (BIPAP)
- Centers for Medicare & Medicaid Services (CMS)
- Cerebrovascular Accident (CVA)
- Continuous Positive Airway Pressure Machine (CPAP)
- Durable Medical Equipment (DME)
- Health-Related Social Needs (HRSN)
- Hemodialysis (HD)
- Inpatient Rehabilitation Facility (IRF)
- Left Ventricular Assist Device (LVAD)
- Level of Care (LOC)
- Long Term Acute Care Hospital (LTACH)
- Occupational Therapy (OT)
- Percutaneous Endoscopic Gastrostomy Tube (PEG)
- Physical Therapy (PT)
- Post-Acute Care (PAC)
- Skilled Nursing Facility (SNF)
- Speech Language Pathology (SLP)
- Traumatic Brain Injury (TBI)

Guideline Scope

This guideline addresses post-acute care (PAC). The criteria below establish the appropriate level of PAC at hospital discharge or upon admission from home. The criteria also establish the appropriateness of continuing care. Specifically, these criteria establish whether a patient can receive care at home or whether a higher level of care is needed. If a higher level of care is appropriate, these criteria determine the most appropriate setting in which to deliver that care: skilled nursing facility, acute inpatient rehabilitation facility, or long-term acute care hospital.

The guideline applies to all patients of all ages and conditions discharged from the hospital. Due to the variety of clinical scenarios in scope, the guideline focuses on the principles needed to establish appropriateness of a given level of PAC.

Definitions

Active medical management – generally requires direct physician monitoring, involvement, or intervention for medical issues at least 3 days per week for inpatient rehabilitation facilities.

Functional impairment – A mobility, self-care, cognitive and/or behavioral-related impairment which has been determined via a comprehensive, skilled assessment of the patient's clinically significant activities on at least one validated functional measure.

Most appropriate PAC Level of Care – the facility type that offers the necessary and appropriate type and intensity of care—including specialized clinical staff and equipment—and no more.

Examples:

- a SNF is a more appropriate level of PAC than an IRF or LTACH if the necessary type and intensity of care can be provided in the SNF environment
- an IRF is a more appropriate level of PAC than an LTACH if the necessary type and intensity of care can be provided in the IRF environment

Post-acute care settings

- **Skilled Nursing Facility (SNF)** – An inpatient facility providing skilled nursing with or without rehabilitative care and classified by CMS as a SNF. Typically, it provides such care on a less than long-term basis and may be free-standing or contained within another medical institution such as a nursing home or acute care hospital. It is traditionally considered the lowest level of facility-based post-acute care, though this may vary depending on the individual facility's characteristics.
- **Inpatient Rehabilitation Facility (IRF)** – An inpatient facility providing high-intensity, multi-disciplinary rehabilitative care coordinated by a rehabilitation physician. IRFs are commonly freestanding but may be contained within an acute care hospital. IRFs are traditionally considered the highest level of rehabilitative post-acute care and intended for patients whose care needs are primarily rehabilitative. Also commonly referred to as "Acute Rehab" or "Acute Inpatient Rehab."
- **Long Term Acute Care Hospital (LTACH)** – An inpatient facility providing medical and rehabilitative care for patients whose medical care needs exceed their rehabilitative care needs and who are expected to require an extended course of medical treatment relative to an acute care hospital (extended course typically expected to be 25 days). Also commonly referred to as Long Term Acute Care (LTAC) or Long-Term Care Hospital (LTCH).

Qualified provider of skilled care – refers to someone who is duly licensed or certified by his/her state to deliver the specific services s/he is rendering and provides such services in accordance with his/her state's respective practice act. State regulations regarding appropriate providers may supersede this guideline.

Clinical Indications

General PAC principles (common to Initial and Ongoing PAC)

- A facility must be sufficiently accessible (e.g., ADA compliant) to avoid compromising a patient's care or their potential to achieve the therapeutic goals
    - Example: for patients whose goals include improved independence with toilet transfers from a wheelchair, a facility without wheelchair-accessible bathrooms would not be appropriate
- Health-related social needs (HRSN) may be considered in determining most appropriate level of care/facility when such issues are noted in the submitted clinical documentation
    - Example: The accessibility of the facility *to those who will be involved in the patient's care upon discharge and need to undergo training throughout the patient's stay* (e.g., a family member who will be patient's primary caregiver in the community) may be considered in the determination of the most appropriate facility

General Criteria for Admission to IRFs

Admission to an IRF is considered medically necessary when ALL the following criteria are met:

- Referral has been ordered by a physician
- Services cannot reasonably and/or safely be provided in a home or community setting due to insufficient availability, intensity, or type of services, and/or necessary equipment is unavailable
- Admission criteria for the IRF has been met (*per "Initial IRF Care" section below*)
- Care will be provided by Qualified Providers (*see Definitions*) of the respective skilled services
- Services ordered are reasonable in scope, intensity, and duration for the condition being treated

Initial IRF Care

Admission to IRF is considered medically necessary when the following general and specialized interventions criteria are met:

ALL the following general criteria:

- An IRF is more appropriate than a SNF or LTACH
- Patient's diagnostic work-up and care plan have largely been determined, and any ongoing medical care needs do not exceed the capabilities of the IRF
- There is documented need for daily, Multi-disciplinary Skilled Rehabilitation interventions (e.g., PT, OT, SLP, psychology, prosthetics/orthotics, rehab nursing, case management). At minimum, the treatment team will include a rehabilitation physician, a registered nurse with specialized training or experience in rehabilitation, therapists from at least 2 disciplines, and a social worker or a case manager.
- Need for rehab program which is closely directed, supervised, and coordinated by a Physical Medicine and Rehabilitation physician (exceptions considered for facilities with no access to a PM&R specialized physician due to geographic limitations for instance)
- Reasonable expectation that patient will be able to participate effectively in and benefit from an intensive, multi-disciplinary rehab program, or otherwise have compelling rehab needs that cannot be adequately addressed at lower level of PAC (e.g., SNF)
- Reasonable expectation and potential for patient to achieve meaningful, quantifiable, and sustained functional improvement
- Reasonable expectation of one of the following discharge dispositions:
    - IRF stay will result in discharge to home and/or community, **or**
    - IRF stay will result in discharge to long-term care with clinically significant improvement in functional independence and burden of care (including improvement in ability to direct their own care)

AND there is documented need for **AT LEAST TWO** of the following three categories of specialized interventions:

- Active Medical Management* during the course of rehabilitation due to a reasonable expectation of **ANY** of the following:
    - Medical stability will be at risk with resumption/progression of activity
    - Patient will have specialized medical needs related to rehab condition
    - Such management will be necessary to maximize participation in therapies and optimize outcomes most efficiently
    - Such management will minimize and simplify medication regimens
    - Such management will facilitate discharge to community at higher level of independence (e.g., earlier decannulation or PEG removal, definitive long-term neurogenic bowel/bladder program,)

  **Active Medical Management generally requires direct physician monitoring, involvement, or intervention for medical issues at least 3 days per week*
- Higher level of rehabilitative care with respect to **one or more** of the following:
    - Degree of specialization
    - Level of intensity
    - Integrated care involving coordination between rehab disciplines (e.g., bowel/bladder management requiring coordination of rehab physician, nursing and therapist care)**,or** between rehab and non-rehab disciplines (e.g., wound management requiring coordination of care between plastic surgery team and rehab team)
- Need for specialized equipment* to:
    - Optimize functional outcomes
    - Avoid or minimize complications of inappropriate equipment (resulting in additional/extended care needs)

- Optimize safety of patient and therapist during treatment (e.g., body weight supported gait training apparatus, tilt table)
- Minimize need for medications during treatment (e.g., enclosure beds and other non-pharmacological restraints for fall prevention in agitated patients)

**Note: Specialized equipment refers to equipment generally available only in the IRF and/or requiring the expertise of the IRF staff to employ appropriately*

AND there is a documented need for **EITHER** of the following reasons for skilled services:

- Functional impairment which reflects a clinically significant decline from (pre-hospitalization) baseline and precludes safe discharge to home
- Complete assessment of caregiving needs and training of caregiver(s) to allow for safe return to community
  - Such caregiver(s) must be identified prior to transfer from acute hospital.
  - There must be a reasonable expectation that caregiver(s) can be adequately trained to meet the patient's care needs fully upon discharge to community

Ongoing Inpatient Rehabilitation Facility Care

Basic Criteria for Continuation of IRF

Continuation of IRF care may be medically necessary when the following criteria are met:

ALL the following general criteria (as applicable to the specific level of PAC):

- Therapeutic goals have been established and documented
- There is at least one remaining therapeutic goal which is likely attainable in a reasonable and predictable timeframe
- There is continued need for skilled medical, nursing, and/or rehabilitation therapy interventions to achieve the remaining therapeutic, education/training, or caregiver goals
- Patient has demonstrated good tolerance of and consistent, meaningful participation in all therapies
- A discharge plan has been formulated and (to the extent possible) executed contemporaneously during stay (so as not to extend stay unnecessarily)
- Progress towards goals has been commensurate with the duration of treatment

and ANY of the following pertaining to patient's progress:

- Patient has had a clinically significant, quantifiable, and favorable response to interventions within a reasonable timeframe, evidenced by:
  - A trend of functional and/or medical improvement (for clinical scenarios wherein progress can reasonably be expected), **or**
  - Sustained prevention of functional and/or medical decline (for clinical scenarios wherein progress cannot reasonably be expected)
- Patient has a lack of clinically significant or favorable response but has an acceptable and temporary mitigating factor(s) accounting for a limited response, such as intervening illness or injury
- Patient has a lack of clinically significant or favorable response, but the plan of care has been modified in a way that is likely to improve the response in a reasonable timeframe
- Unmet goal of patient/family/caregiver education that can be achieved in reasonable timeframe relative to condition or length of stay (requires demonstrated participation/compliance)

Note: such education/training is expected to have been ongoing throughout the stay, this pertains to aspects which could not have been completed earlier (e.g., due to evolving clinical situation)

- Patient has had a change in status that:
    - enables upgraded goals*,
    - improves potential (e.g., non-weight bearing to weight bearing as tolerated, upgraded dysphagia diet, improved medical condition), **and/or**
    - would facilitate earlier discharge to community (e.g., decannulation, upgrade to po diet from PEG)

    **Note: goals must still require IRF-based care to achieve*
- Patient's current home environment cannot safely accommodate patient's functional and/or medical needs but will be able to within a reasonable period of patient achieving the established therapeutic goals with:
    - appropriate structural modifications, **and/or**
    - patient's functional improvement from skilled interventions, **and/or**
    - necessary caregiver services arranged

and ALL additional criteria (below) are met either for continuation of current IRF level of care, transfer to LTACH level of care, or transfer to SNF level of care

Level of Ongoing Facility-Based PAC

Continuation of IRF-level care may be considered medically necessary when the following are or continue to be met:

- **ALL** Basic Criteria for Continuation of IRF-based PAC
- **ALL** criteria for admission to the IRF (*per "Initial IRF care" section*)

Transfer to a LTACH may be considered medically necessary when the following criteria are met:

- LTACH is the Most Appropriate Level of Care
    - **Most Appropriate PAC Level of Care** – the facility type that offers the necessary and appropriate type and intensity of care—including specialized clinical staff and equipment—and no more
- **ALL** Basic Criteria for Continuation of LTACH-based PAC (*Also see the Appropriate Use Criteria- LTACH guideline*)
- **ALL** criteria for admission to the LTACH (*per "Initial LTACH care" section in Appropriate Use Criteria- LTACH guideline*)
- Patient has a change in medical status that requires more specialized evaluation, testing, and management than can be performed in current facility but does not require or is not suitable for an acute care hospital

Transfer to SNF may be appropriate when the following criteria are met:

- **ALL** criteria for admission to SNF *(per "Initial SNF care" criteria in SNF Appropriate Use Criteria guideline*)
- **ALL** Basic Criteria for Continuation of SNF-based PAC *(per SNF Appropriate Use Criteria guideline*)
- SNF is the Most Appropriate Level of Care

    - **Most Appropriate PAC Level of Care** – the facility type that offers the necessary and appropriate type and intensity of care—including specialized clinical staff and equipment—and no more
- Criteria for admission to IRF are no longer met

and ANY of the following, as applicable to the specific PAC level:

- Discharge to community has become unrealistic, but continued skilled therapies are needed to improve, preserve, or slow decline of medical or functional status and decrease burden of care
- Patient is unwilling or unable to meaningfully participate in the required level of therapies but still requires facility-based, skilled medical or nursing care.
- Patient has a change in medical and/or functional status that impedes ability to participate effectively and/or progress but doesn't require acute care hospital (e.g., new weight-bearing restriction)
- Patient no longer requires close, Active Medical Management and is unable to participate in therapies or to function safely in a home or community setting
- Patient needs more limited Active Medical Management (e.g., medical management has been optimized) and/or rehab care (e.g., < daily therapy) but could still benefit from continued skilled care (e.g., CVA patient who still requires supervision with ADLs and on a restricted diet, but blood pressure is stable)
- Patient has substantially met established therapeutic goals and can achieve remaining improvement with less intense or specialized care in home setting

Exclusions

IRF care (initiation or ongoing) will be considered **Not Medically Necessary** when:

- There is no reasonable expectation of progression towards goals.

  Examples:

    - There is a cognitive condition such as dementia that is likely to preclude effective learning and carry-over when goals depend on such abilities
    - Identified caregiver is unwilling or unable to provide the necessary care for patients whose goals depend on caregiver involvement.
    - A caregiver is unavailable or unable to participate in the education and training with the patient as needed to achieve therapeutic goals
- Services otherwise do not meet clinical criteria outlined above

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History

Status	Review Date	Effective Date	Action
Updated	01/23/2024	Unchanged	Independent Multispecialty Physician Panel (IMPP) review of General Clinical Guideline. Added required language per new Medicare regulations.
Updated	n/a	Unchanged	Disclaimers updated from Post Acute Solutions to Carelon Medical Benefits Management.
Created, Revised	04/12/2023, 02/03/2022	09/01/2023	IMPP review. Restructured by level of care and clarified admission criteria. Original effective date.