
HCFA Rulings

Department of Health
and Human Services

Health Care Financing
Administration

Ruling No. 85-2

Date: 1982

HCFAR 85-2-1

MEDICARE PROGRAM

Hospital Insurance Benefits Program (Part A)

Criteria for Medicare Coverage of Inpatient Hospital Rehabilitation Services

HCFAR 85-2

Purpose: This Ruling provides further public notice of HCFA's criteria for Medicare coverage of inpatient hospital rehabilitation services.

Citations: Sections 1812, 1814, 1861 and 1862 of the Social Security Act (the Act) (42 U.S.C. 1395d, 1395f, 1395x, and 1395y); 42 CFR 401.108 and 42 CFR 405.310(k); 50 FR 31040, July 31, 1985.

Pertinent History: Under the Medicare program, there has always been a statutory exclusion of payment for services that "... are not reasonable and necessary for the diagnosis or treatment of illness or injury ..." (section 1862(a)(1) of the Act). It is this authority, taken in conjunction with the descriptions of the various benefits, that the program uses to deny payment when services required by a patient could have been appropriately provided in an inpatient setting which is less intensive than the hospital setting or in an outpatient setting. (See also section 1154 of the Act.)

Rehabilitation care is furnished in a variety of settings ranging from the inpatient hospital setting, through the skilled nursing facility setting, to various outpatient settings such as, for example, home health care and outpatient physical therapy. To determine whether inpatient hospital care is necessary for the provision of rehabilitation services, it is first necessary to determine what rehabilitation services the patient requires and then to determine whether they need to be provided in the inpatient hospital setting.

HCFAR 85-2-2

Typically, a preadmission screening is done before a patient is admitted to a rehabilitation hospital. This screening is a preliminary review of the patient's condition and previous medical record to determine if the patient is likely to benefit significantly from an intensive hospital program or extensive inpatient assessment.

Further inpatient assessment of a patient's potential for rehabilitation may be done if it is reasonable and necessary to perform the assessment in the hospital.

We developed criteria early in the program to assist medical review entities in applying the basic "reasonable and necessary" test to inpatient rehabilitation services under Part A. These criteria are used to help a medical review entity determine whether rehabilitative care in a hospital, rather than in a SNF or on an outpatient basis, is reasonable and necessary. The criteria have been revised from time to time to respond to new questions of interpretation which have arisen. Section 3101.11 of the Intermediary Manual contains the current version of these criteria. The HCFA Ruling published in this notice restates the criteria set forth in that manual.

Ruling

- A. General. – Physicians generally agree on the circumstances that justify a medical or surgical patient's hospitalization, and, in some cases, an admission to a rehabilitation hospital or to the rehabilitation service of a short-term hospital can be justified on essentially the same medical or surgical grounds. In other cases, however, a patient's medical or surgical needs alone may not warrant inpatient hospital care, but hospitalization

HCFAR 85-2-3

may nevertheless be necessary because of the patient's need for rehabilitative services.

A hospital level of care is required by a patient needing rehabilitative services if that patient needs a relatively intense rehabilitation program that requires a multidisciplinary coordinated team approach to upgrade his ability to function. There are two basic requirements which must be met for inpatient hospital stays for rehabilitation care to be covered:

1. The services must be reasonable and necessary (in terms of efficacy, duration, frequency, and amount) for the treatment of the patient's condition; and
 2. It must be reasonable and necessary to furnish the care on an inpatient hospital basis, rather than in a less intensive facility, such as a SNF, or on an outpatient basis.
- B. Preadmission Screening. – Before a patient is admitted to a rehabilitation hospital for treatment, a preadmission screening is normally done. This screening is a preliminary review of the patient's condition and previous medical record to determine if the patient is likely to benefit significantly from an intensive hospital program or extensive inpatient assessment.

While preadmission screening is a standard practice in most rehabilitation hospitals and may provide useful information for claims review purposes, the absence of a preadmission screening in a particular case should not be the sole reason for denying a claim. However, in a case where an inpatient assessment showed that a patient clearly was not

HCFAR 85-2-4

a good candidate for an inpatient hospital program, then the presence or absence of preadmission screening information would be important in determining whether the inpatient assessment itself was reasonable and necessary. If preadmission screening information indicated that the patient had the potential for benefiting from an inpatient hospital program, a period of inpatient assessment could be covered up to the point where it was determined that inpatient hospital rehabilitation was not appropriate, since preadmission screening cannot be expected to eliminate all unsuitable candidates.

C. Inpatient Assessment of an Individual's Status and Potential for Rehabilitation.

1. General. – Coverage is available for inpatient assessment of a patient's potential for benefiting from an intensive coordinated rehabilitation program only if it was reasonable and necessary to perform the assessment in the hospital. This determination should be made on the basis of information available in the patient's medical record. It is important to note that the assessment process is not merely a paperwork review, but rather an onsite professional review of the patient's condition by the necessary disciplines. Inpatient assessments conducted by a rehabilitation team through examination of the patient usually require between 3 to 10 calendar days, but on occasion may require more. This 3-10 day period is often one where the patient is receiving therapies rather than simple screening assessments. Where more than 10 days are required, the case should be carefully reviewed to ensure that such additional time was

HCFAR 85-2-5

necessary. An inpatient assessment may be covered even if the assessment subsequently indicates that a patient is not suitable for an intensive inpatient hospital rehabilitation program, if the patient's condition on admission was such that an extensive inpatient assessment was considered reasonable and necessary for a final decision to be made on a patient's actual rehabilitation potential. Where the initial assessment has resulted in a conclusion that the individual is a poor candidate for rehabilitation care, coverage for further inpatient hospital care is limited to a reasonable number of days needed to permit appropriate placement of the patient.

The fact that an individual received therapy prior to admission to a hospital for a rehabilitation program would not necessarily mean that the initial assessment period was not reasonable and necessary. However, if during a previous hospital stay an individual completed such a program for essentially the same condition for which inpatient hospital care is now being provided, the assessment period could be covered only if:

- (1) Some intervening circumstance rendered such an assessment reasonable and necessary; or

- (2) The subsequent admission is to an institution utilizing techniques or technology not previously available or not available in the first institution.

2. Specific examples:

- a) After an inpatient hospital stay for rehabilitation care which resulted in little improvement in the patient's condition, an

HCFAR 85-2-6

individual who undergoes surgery for severe contractures as a result of arthritis may require a reassessment of his rehabilitation potential in light of the surgery.

- b) The fact that an individual has some degree of mental impairment would not per se be a basis for concluding that a multidisciplinary team evaluation is not warranted. Many individuals who have had CVAs¹ suffer both mental and physical impairments. The mental impairment often results in a limited attention span and reduced comprehension with a resultant problem in communication. With an intensive rehabilitation program, it is sometimes possible to correct or significantly alleviate both the mental and physical problems.
- c) Absent other complicating medical problems, the type of rehabilitation program normally required by a patient with a fractured hip during or after the nonweightbearing period or a patient with a healed ankle fracture would not require an inpatient hospital stay for rehabilitation care. Accordingly, an inpatient assessment would not be warranted in such cases. On the other hand, an individual who has had a CVA which has left the individual significantly dependent in the activities of daily living (even after physical therapy in a different setting) might be a good candidate for a more extensive inpatient assessment

HCFAR 85-2-7

if the patient has potential for rehabilitation and his needs are not primarily of a custodial nature.

- D. Inpatient Rehabilitation Hospital Care. – Rehabilitative care in a hospital, rather than in a SNF or on an outpatient basis, is reasonable and necessary for a patient who requires a more coordinated, intensive program of multiple services than is generally found out of a hospital. A patient who has one or more conditions requiring intensive and multidisciplinary rehabilitation care, or who has a medical complication in addition to his primary condition, so that the continuing availability of a physician is required to ensure safe and effective

¹ Cerebrovascular accidents

treatment, would probably require a hospital level of rehabilitation care. A patient in need of rehabilitation on an inpatient hospital basis requires all of the following:

1. Close medical supervision by a physician with specialized training or experience in rehabilitation. – A patient's condition must require the 24-hour availability of a physician with special training or experience in the field of rehabilitation. This need should be verifiable by entries in the patient's medical record that reflect frequent and direct and medically necessary physician involvement in the patient's care; i.e., at least every 2-3 days during the patient's stay. This degree of physician involvement, which is greater than would normally be rendered to a patient in a SNF, is an indicator of a patient's need for services generally available only in a hospital setting. A SNF patient's care would usually require only the general supervision of a physician, rather than the close supervision which hospital patients need.

HCFAR 85-2-8

2. Twenty-four hour rehabilitation nursing. – The patient requires the 24-hour availability of a registered nurse with specialized training or experience in rehabilitation. This degree of availability represents a higher level of care than would normally be found in a SNF. While a SNF patient may require nursing care, specialized rehabilitation nursing is generally not as readily available in such a facility.
3. A relatively intense level of physical therapy or occupational therapy and, if needed, speech therapy, social services, psychological services, or prosthetic-orthotic services. – The patient must require at least 3 hours a day of physical and/or occupational therapy, in addition to any other required therapies or services. In exceptional cases, an inpatient hospital stay for rehabilitation care can be covered even though the patient has a secondary diagnosis or medical complication that prevents him from participating in programs of physical or occupational therapy to the extent outlined above. Inpatient hospital care in these cases may be the only reasonable means by which even a low intensity rehabilitation program can be safely carried out. Documentation must be secured of the existence and extent of complicating conditions affecting the carrying out of a rehabilitation program to ensure that inpatient hospital care for less than intensive rehabilitation care is actually needed.
4. A multidisciplinary team approach to the delivery of the program. – A multidisciplinary team usually includes a physician, rehabilitation nurse, social worker and/or psychologist, and those therapists involved in the patient's care. At a minimum, a team must include a physician, rehabilitation nurse and one therapist.

5. A coordinated program of care. – The patient's records must reflect evidence of a coordinated program, i.e., documentation that periodic team conferences were held with a regularity of at least every 2 weeks to: (1) assess the individual's progress or the problems impeding progress; (2) consider possible resolutions to such problems; and (3) reassess the validity of the rehabilitation goals initially established. A team conference may be formal or informal; however, a review by the various team members of each other's notes would not constitute a team conference. The decisions made during such conferences, such as those concerning discharge planning and the need for any adjustment in goals or in the prescribed treatment program, must be recorded in the clinical record.
6. Significant practical improvement. – Hospitalization after the initial assessment is covered only in those cases where the initial assessment results in a conclusion by the rehabilitation team that a significant practical improvement can be expected in a reasonable period of time. It is not necessary that there be an expectation of complete independence in the activities of daily living, but there must be a reasonable expectation of improvement that will be of practical value to the patient, measured against his condition at the start of the rehabilitation program. For example, a multiple sclerosis patient's condition may have deteriorated as a result of a secondary illness. To be restored to a level of function before the secondary illness, the patient may require an intensive inpatient hospital rehabilitation program. While such a program would not restore the

HCFAR 85-2-10

level of function before multiple sclerosis developed, a return to pre-secondary illness level would be considered to be a "significant practical improvement" in the condition.

7. Realistic goals. – While there may be instances where an intense rehabilitation program may enable a Medicare patient to return to the labor market, vocational rehabilitation is generally not considered a realistic goal for most aged or severely disabled individuals. The most realistic rehabilitation goal for most Medicare beneficiaries is self-care or independence in the activities of daily living; i.e., self-sufficiency in bathing, ambulation, eating, dressing, homemaking, etc., or sufficient improvement to allow a patient to live at home with family assistance rather than in an institution. Thus, the aim of the treatment should be achieving the maximum level of function possible.
8. Length of the rehabilitation program. – Coverage should stop when further progress toward the established rehabilitation goal is unlikely or it can be achieved in a less intensive setting. In deciding whether further care can be carried out in a less intensive setting, both the degree of improvement which has occurred and the type of program required to achieve further improvement must be considered. In some cases an individual may be expected to continue to improve under an outpatient program. There are other situations where further improvement in the individual's ability to

function relatively independently in the activities of daily living can be expected only if a multidisciplinary team effort is continued.

HCFAR 85-2-11

While occasional home visits and other trips into the community are factors in determining whether continued stay in the hospital is necessary, such excursions would not alone be a basis for concluding that further hospital care is not required. Planned home visits and trips to the community are frequently used to test the individual's ability to function outside the institutional setting and to assist in discharge planning for the individual.

It is also important to consider how close the patient may be to the planned end of his rehabilitation hospital stay when further progress becomes unlikely. If a patient is within a few days of discharge, it would usually not be appropriate to transfer him to a less intensive setting in another facility even though further progress in the hospital setting is unlikely. However, it could be appropriate to utilize a "swing bed" arrangement, if it exists in the same facility, for rendering necessary services to the patient pending discharge.

When discharge or transfer to another facility is appropriate, the cut-off point for coverage should not be the last day on which improvement actually occurred. Rather coverage should continue through the time it would have been reasonable for the physician, in consultation with the rehabilitation team, to have concluded that further improvement would not occur and to have initiated the patient's discharge.

Since discharge planning is an integral part of any rehabilitation program and should begin upon the patient's admittance to the

HCFAR 85-2-12

facility, an extended period of time for discharge action would not be reasonable after established goals have been reached, or after a determination has been made that further progress is unlikely or that care in a less intensive setting would be appropriate.

Effective Date: July 31, 1985.