

Table of Contents

1.0	Description of the Procedure, Product, or Service.....	1
2.0	Eligible Recipients.....	1
2.1	General Provisions.....	1
3.0	When the Procedure, Product, or Service Is Covered.....	1
3.1	General Criteria.....	1
3.2	Specific Criteria.....	1
4.0	When the Procedure, Product, or Service Is Not Covered.....	4
4.1	General Criteria.....	4
4.2	Specific Criteria.....	4
5.0	Requirements for and Limitations on Coverage.....	4
5.1	Prior Approval.....	4
6.0	Providers Eligible to Bill for the Procedure, Product, or Service.....	5
7.0	Additional Requirements.....	5
7.1	Compliance.....	5
8.0	Policy Implementation/Revision Information.....	5
	Attachment A: Claims-Related Information.....	6
A.	Claim Type.....	6
B.	Diagnosis Codes.....	6
C.	Procedure Code(s).....	6
D.	Modifiers.....	6
E.	Billing Units.....	6
F.	Place of Service.....	6
G.	Co-payments.....	6
H.	Reimbursement.....	6

1.0 Description of the Procedure, Product, or Service

An inpatient rehabilitation facility (IRF) is an inpatient rehabilitation hospital or distinct part rehabilitation units in a hospital institution licensed under applicable state laws and engaged primarily in providing to inpatients, under the supervision of a doctor and a registered professional nurse, skilled nursing care on a 24-hour basis and an inpatient level of intensive rehabilitative services. A hospital inpatient level of care would be required if a IRF were not available, and other alternative levels of care, such as skilled nursing facilities, office, outpatient, home are unable to provide the frequency and/or intensity of services needed.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NCHC recipients must be enrolled on the date of service.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

NCHC covers procedures, products, and services related to this policy when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; **AND**
- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

- a. Charges for services received in an IRF fall into two distinct categories - routine and ancillary. In providing benefits for services received in an IRF, distinction is made between routine and ancillary charges for purposes of reimbursement. Regardless of the manner in which the services are billed, routine services are not paid as items separate from accommodation charges. However, ancillary charges, if covered, are paid apart from the charge for room accommodation:
 1. The following are covered in an IRF:
 - (a) Daily charges for room and board, up to the semi-private room rate, as outlined below
 - (b) Ancillary charges and other services ordinarily covered in a general hospital, as outlined below

2. Routine services which should be included in the accommodation charge include:
 - (a) Medical social services;
 - (b) All general nursing services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas;
 - (c) Items furnished routinely and relatively uniformly to all recipients; e.g., recipient gowns, paper tissues, water pitchers, bedpans, deodorant and mouthwash;
 - (d) Items stocked at the nursing station or on the floor in large quantity and distributed individually in small amounts, e.g., alcohol, applicators, cotton balls, Band-aids, Maalox, aspirin (and other non-legend drugs ordinarily kept on hand), suppositories and tongue depressors;
 - (e) Items which are utilized by individual recipients but which are reusable and expected to be available in an institution providing a skilled level of care; e.g., ice bags, bedrails, canes, crutches, walkers, wheelchairs, IV poles and pumps, traction equipment and other durable medical equipment;
 - (f) Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as prescription items by a physician;
3. To be considered as **ancillary charges**, payable as separate items when billed by an IRF, services must be:
 - (a) Directly identifiable services provided to an individual at the direction of a physician because of a specific medical need, e.g., physical therapy, occupational therapy and speech therapy;
 - (b) Either not reusable (e.g. legend drugs, irrigation solutions, IV fluids, oxygen, disposable catheters), or represent a cost for each use (e.g., sterilization and set-up of reusable catheters).
- b. Benefits are provided for IRF care when ALL of the following conditions are met:
 1. The recipient has one or more disabling medical or surgical primary conditions requiring intensive multidisciplinary rehabilitation care. In determining the appropriate setting for provision of rehabilitation services, DMA's vendor may refer to and utilize other approved guidelines, such as Milliman Care Guidelines. **AND**
 2. The recipient requires moderate to maximum assistance or greater in ambulation/mobility and greater than minimal assistance in AT LEAST TWO (2) of the following areas:
 - (a) Activities of daily living: Greater than minimal assistance is required in self care activities such as eating, drinking, dressing, applying brace or prosthesis, toileting, transferring or maintaining personal hygiene.

- (b) Perceptual motor dysfunction, such as decreased spatial orientation, or depth or distance perception
 - (c) Communication disorder, such as aphasia with major receptive or expressive dysfunction or significant swallowing disorder
 - (d) Incontinence of bowel or bladder
 - (e) Cognitive function, such as decreased memory span, memory, or intelligence;
3. Intensity of service: The request must meet AT LEAST ONE (1) of the following two criteria:
- (a) An inpatient intensity and duration of rehabilitative services shall be provided as evidenced by at least three hours per day, 6 days a week or more of physical therapy and one or more other rehabilitative modality, (either occupational therapy or speech therapy); **OR**
 - (b) There is an active, temporarily unstable medical condition under treatment that would qualify for acute medical/surgical hospital benefits for the provision or administration of services or procedures that can only be provided by a skilled nurse at a higher intensity than a SNF;
4. The proposed therapies shall be performed to achieve a specific diagnosis-related goal for a recipient who has a reasonable expectation of achieving measurable improvement in a reasonable and predictable period of time;
5. The recipient must be able to follow instructions or, if not, the recipient must have demonstrated significantly improved cognitive functioning over the preceding fourteen day period (serial Glasgow and/or Ranchos scores shall be submitted); **AND**
6. The recipient remains under the continual care of an attending physician who evaluates the recipient through an on-site visit at least once a day.
- c. Benefits are provided for a continued stay in IRF when ALL of the following medically necessary criteria are met:
- 1. Established long term goals have not been attained; rehabilitation plans call for continued intensive rehabilitative therapy of three hours per day, six days a week; the goals have a reasonable expectation of being achieved with measurable improvement in a reasonable and predictable period of time;
 - 2. A majority of short term goals have been met; further progress is likely because significant progress has been demonstrated over the past initial period prior to the current date of review. **AND**
 - 3. A determination has been made that a less intensive inpatient setting is not yet appropriate; **AND**
 - 4. Active discharge planning evaluation has been documented in weekly team meeting notes. Barriers to discharge have been identified and addressed.

4.0 When the Procedure, Product, or Service Is Not Covered

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental or investigational.

4.2 Specific Criteria

There are no specific criteria for when IRF is not covered.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

- a. Prior approval is required for IRF benefits.
- b. A letter of medical necessity and plan of treatment signed and dated by the facility attending physician must be submitted to DMA's vendor prior to rendering the service.
- c. Documentation must include:
 1. Recipient Demographics, including name, address, NCHC ID number;
 2. Medical diagnosis, including recipient's physical and mental status and the necessity for intensive rehabilitation;
 3. Documentation from the qualifying acute-care facility admission: admission history and physical and discharge summary or most current history and physical;
 4. Current therapy notes (from IP setting) for the previous 3-4 days; and
 5. Specific skilled services and life supports required on a continuing basis (e.g. Intravenous therapy, feeding tubes, ventilatory support);
 6. Current formal functional evaluation by rehabilitative staff from IRF;
 7. Type, duration per day and frequency of rehabilitation therapy services the recipient is to receive at IRF;
 8. Rehabilitation goals, time frames, expected duration of stay and proposed discharge plan from IRF;
 9. Documentation indicating the recipient's prior functioning level before admission and the support the recipient will have at home;
 10. Attending physician's name and provider number.

Note: Refer to **Subsection 3.2.b** and **3.2.c** above.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet NCHC qualifications for participation;
- b. be currently enrolled with NCHC; **AND**
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.0 Additional Requirements

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
July 1, 2010		Policy Conversion: Implementation of Session Law 2009-451, Section 10.32 “NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY.”
11/30/2012	All sections and attachments	Policy Termination

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

Revenue Codes				
118	128	138	158	25X
26X	27X	29X	30X	32X
410	412	419	42X	43X
44X	47X	73X	880	881
889	93X			

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

The appropriate procedure code(s) used determines the billing unit(s).

F. Place of Service

Inpatient Hospital (rehabilitation facility or unit within acute care hospital)

G. Co-payments

Co-payment(s) may apply to covered prescription drugs and services.

H. Reimbursement

Providers must bill their usual and customary charges.