BENEFIT COVERAGE POLICY

Title: BCP-23 Inpatient Rehabilitation (IPR) Services

Effective Date: 10/01/2022

Physicians Health Plan
PHP Insurance Company
PHP Service Company

Important Information - Please Read Before Using This Policy

The following coverage policy applies to health benefit plans administered by PHP and may not be covered by all PHP plans. Please refer to the member's benefit document for specific coverage information. If there is a difference between this general information and the member's benefit document, the member's benefit document will be used to determine coverage. For example, a member's benefit document may contain a specific exclusion related to a topic addressed in a coverage policy.

Coverage determinations for individual requests require consideration of:

1. The terms of the applicable benefit document in effect on the date of service.
2. Any applicable laws and regulations.
3. Any relevant collateral source materials including coverage policies.
4. The specific facts of the particular situation.

Contact PHP Customer Service to discuss plan benefits more specifically.

1.0 Policy:

Please refer to the member's benefit plan coverage guidelines for inpatient rehabilitation (IPR) services. Benefit plans may include a maximum allowable benefit, either in duration of treatment or in number of visits, for example. When the maximum allowable benefit is exhausted, coverage may no longer be provided even if the medical necessity criteria are met.

For all non-network covered services to be paid at the network benefit level except for emergency/urgent services, prior approval is required.

Health Plan considers non-Hospital facility services at an Inpatient Rehabilitation Facility medically necessary and requires prior approval. Coverage includes the facility charge, charges for required services, professional fees, medical supplies and equipment.

Unlisted codes are subject to review.

This policy does not guarantee or approve Benefits. Coverage depends on the specific Benefit plan. Benefit Coverage Policies are not recommendations for treatment and should not be used as treatment guidelines.

Delegated vendor guidelines may be used to support medical necessity and other coverage determinations. InterQual® references are available upon request.

2.0 Background:

Coverage for acute, inpatient rehabilitation requires prior approval. IPR provides an intensive, multi-disciplinary rehabilitation program for patients with conditions such as stroke, trauma, and brain injury. Therapy is provided in a specially designated area of an acute care hospital or facility. Patients receive rehabilitation nursing, physical, occupational, and speech therapy and are medically managed by specially trained physicians. An attending physician is onsite 24 hours a day to manage the medical aspects of each patient's care.

For patients with neurological diagnoses, a neuropsychologist is on staff to determine if they need additional psychological of psychiatric treatment. In an acute rehabilitation program, the patient is expected to make significant functional gains and medical improvement within a reasonable time frame. A patient must be able to tolerate an intensive level of rehabilitation services consisting of a minimum of three hours of therapy per day, up to six days a week. Therapy is provided on both a one-

to-one and group basis, depending on the needs of the individual. Additional services are also available, such as respiratory therapy, social worker assistance, and therapeutic recreation programs.

3.0 Clinical Determination Guidelines:

A. Health Plan uses InterQual® guidelines for clinical review of inpatient acute rehabilitation admissions.

B. Inpatient rehabilitation provides nursing and therapy services to a member who is medically stable and is able to participate in, and benefit from intensive rehabilitation and:

1. Intense and complex care needs make inpatient care safer and more practical than care at a lower level and,
2. Multidisciplinary therapy services needed for safety and to achieve medically desired results, e.g., physical therapy, occupational therapy, speech-language pathology therapy, orthotics/prosthetics and nursing.

4.0 Coding:

Prior Approval Legend: Y = All lines of business; N = None required; 1 = HMO/POS; 2 = PPO; 3 = ASO group L0000264; 4 = ASO group L0001269 Non-Union & Union; 5 = ASO group L0001631; 6 = ASO group L0002011; 7 = ASO group L0001269 Union Only; 8 = ASO group L0002184; 9 = ASO group L0002237.

Note: see PRP-14 Inpatient Rehabilitation (IPR) Facility Charges for revenue codes for facility billing.

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Reference**
99221	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit. Initial hospital care, per day, for E&M of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive exam; and Medical decision making that is straightforward or of low complexity.	N	Professional Fees for Surgical and Medical Services
99222	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or	N	Professional Fees for Surgical and Medical Services

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Reference**
	coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.		
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	N	Professional Fees for Surgical and Medical Services
99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.	N	Professional Fees for Surgical and Medical Services
99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate	N	Professional Fees for Surgical and Medical Services

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Reference**
	complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.		
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.	N	Professional Fees for Surgical and Medical Services
99234	Observation or inpatient hospital care, for E&M of a patient including admission and discharge on the same date, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive exam; and Medical decision making that is straightforward or low complexity	N	Professional Fees for Surgical and Medical Services
99235	Observation or inpatient hospital care, for E&M of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity	N	Professional Fees for Surgical and Medical Services
99236	Observation or inpatient hospital care, for E&M of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high	N	Professional Fees for Surgical and Medical Services

COVERED CODES			
Code	**Description**	**Prior Approval**	**Benefit Plan Reference**
	complexity		
99238	Hospital discharge day management; 30 minutes or less	N	Professional Fees for Surgical and Medical Services
99239	Hospital discharge day management; more than 30 minutes	N	Professional Fees for Surgical and Medical Services

5.0 Unique Configuration/Prior Approval/Coverage Details:

None.

6.0 Terms & Definitions:

Inpatient Rehabilitation Facility – a hospital or a special unit of a hospital that provides inpatient services such as physical therapy, occupational therapy, and speech therapy.

7.0 References, Citations & Resources:

1. Medicare Interactive.org available at: https://www.medicareinteractive.org/get-answers/medicare-covered-services/inpatient-hospital-services/inpatient-rehabilitation-hospital-care

8.0 Associated Documents [For internal use only]:

Standard Operating Procedures (SOPs) –MMS-03 Algorithm for Use of Criteria for Benefit Determinations; MMS-05 Completing a HCN; MMS-06 Identification of Cases; MMS-09 Case Management Referrals.
Policies and Procedures (P&Ps) - MMP-09 Benefit Determinations.
Payment Reimbursement Policies (PRPs) - PRP-14 Inpatient Rehabilitation Facility Charges.

9.0 Revision History:

Original Effective Date: 01/01/2020

Next Review Date: 10/01/2022

Revision Date	Reason for Revision
February 2019	Policy created; approved by BCC 10/7/19
9/20	Annual review, references to MCG replaced with InterQual
6/21	Annual review, updated internal associated documents
7/22	Annual review; no changes