CIGNA MEDICAL COVERAGE POLICY

The following Coverage Policy applies to all health benefit plans administered by CIGNA Companies including plans formerly administered by Great-West Healthcare, which is now a part of CIGNA.

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Subject Inpatient Acute Rehabilitation

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INSTRUCTIONS FOR USE

*Coverage Policies are intended to provide guidance in interpreting certain **standard** CIGNA HealthCare benefit plans. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement (GSA), Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document **always supercedes** the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines.*

Coverage Policy

Under many benefit plans, coverage for inpatient acute rehabilitation is subject to the terms, conditions, and limitations of the Other Participating Health Care Facility/Other Health Care Facility benefit as described in the applicable plan document.

CIGNA covers inpatient acute rehabilitation as medically necessary when ALL of the following criteria are met:

- The complexity of the individual's nursing; medical management; and rehabilitation needs require an inpatient interdisciplinary team approach for delivery of care, including ALL of the following.
  - 24-hour per day access to a registered nurse with specialized training in rehabilitation care.
  - frequent rehabilitation team assessment and intervention due to the potential risk of significant change in physical or medical status.
  - The rehabilitation services require such an intensity, frequency and duration as to make it impractical for the individual to receive services in a less intense care setting.
- The rehabilitative treatment plan includes at least two therapies (e.g., physical therapy, occupational therapy, speech therapy).
- The individual is stable enough medically and is capable and willing to participate in intensive therapy for a minimum of three hours per day, at least five days per week.
- The rehabilitation program is expected to result in significant therapeutic improvement over a clearly defined period of time.
- The rehabilitation program is individualized, and documentation outlines quantifiable, attainable treatment goals.

- Supervision is provided by a physician with specialized training or experience in rehabilitation, including face-to-face visits at least three days per week to assess the individual both medically and functionally and make appropriate modifications to the course of treatment based upon the individual's medical condition and progress.

Note: Continued coverage for inpatient acute rehabilitation requires regular documentation supporting significant progress toward treatment goals.

CIGNA does not cover inpatient acute rehabilitation when ANY of the following applies because it is not medically necessary:

- the individual's condition is such that it would be appropriate to receive medically necessary services in a less intense setting (e.g., skilled nursing facility or outpatient)
- coordinated multidisciplinary care is not provided or required
- documentation in the medical record does not support the need for intensive inpatient rehabilitation
- treatment provided to prevent or slow deterioration in function or prevent reoccurrences
- treatment intended to improve or maintain general physical condition
- long-term rehabilitative services when significant therapeutic improvement is not expected
- services for the purpose of enhancing job, school or athletic performance, or for recreation

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General Background

Patients admitted to inpatient facilities frequently suffer from comorbidities in addition to the primary diagnosis which necessitated hospitalization. Patients hospitalized for acute episodes are at risk of experiencing significant loss of functioning as a result of inactivity, immobility and, in some cases, prolonged bed rest. The risk of significant loss of functioning is generally increased in patients who are critically ill, in patients with complications, during long-term intensive care stays, in persons with disabilities, and in patients with pre-existing chronic conditions, as well as in the elderly. It is recommended that loss of functioning should be addressed as early as possible during an acute hospital stay in order to minimize further loss and to optimize recovery and early autonomy (Stucki, et al., 2005). Early identification of rehabilitation needs and early start of rehabilitation can also reduce length of stay and help prevent disability.

Inpatient acute rehabilitation provides intense multidisciplinary services to restore or enhance function post-injury or illness. While services are based on the assessment of each individual patient's needs, the services must be medically necessary to help patients achieve the skills required to return to their maximum level of functional independence. Furthermore, while initiation and intensity of therapy varies for each medical condition, patients who are not medically stable are not considered candidates for rehabilitative care. The services may be provided in an acute care hospital or in a subacute or less intense setting (i.e., skilled nursing facility [SNF]) or other outpatient setting. For some patients, rehabilitation services are appropriate when provided in the home setting.

The ideal and most intense level of care for medically complex patients is the acute hospital rehabilitation setting. This patient subgroup must require and be able to tolerate three or more hours of intense therapy and have the potential for functional improvement. Patients requiring subacute care typically do not require acute care services but continue to require short-term, complex medical and rehabilitative interventions provided by a physician-directed interdisciplinary team. Patients who are elderly and deconditioned may tolerate better the less intense therapy provided in an SNF or home program. Patients typically referred to an SNF-based program are those who require skilled therapy but no other types of rehabilitation (e.g., recovering from hip fracture) and those patients who cannot tolerate the intensity of an inpatient program. When home care programs are utilized, patients must have adequate social resources and be medically stable. Home care programs can be limited due to lack of equipment. Outpatient therapy is generally appropriate for patients who require multiple disciplines, interdisciplinary team intervention, and have adequate social support. Individual outpatient therapy is indicated when a single discipline is required (Warshaw, 1999).

Patients who meet criteria for an inpatient rehabilitation facility (IRF) as a result of severe neurological impairment often require bowel and bladder management, skin care, tube feedings and the use of adaptive

equipment for positioning. In most cases when the patient has limited potential for improvement (i.e., anticipated short rehabilitation stay) and committed caregivers, during the approved inpatient rehabilitation stay, caregivers may benefit from education and training that emphasizes the care of a severely neurologically impaired patient while in a home setting.

Although many patients do not receive specialized rehabilitation during the acute hospital stay, in some cases rehabilitation is needed after amputation, stroke, cardiac events, or other conditions that result in deconditioning and/or varying degrees of functional loss. Recently, CMS issued a final rule regarding revisions to classification criteria, known as "the 75% rule," which is used to classify a hospital as an inpatient rehabilitation facility. This final rule also modified and expanded the list of clinical groups in the regulatory requirements (CMS, 2004). These clinical groups include the following:

- stroke
- spinal cord injury
- brain injury
- congenital deformity
- neurological disorders
- hip fracture
- amputation
- severe or advanced osteoarthritis involving two or more weight-bearing joints
- rheumatoid, other arthritis
- systemic vasculidities with joint inflammation
- major multiple trauma
- burns
- hip or knee replacement, or both

A physician referral/order to initiate formal rehabilitation is required and should establish the goals of therapy. Acute rehabilitation benefits patients who are cognitively intact and who can participate in at least three hours of therapy each day (McClelland, et al., 2003). Rehabilitation services employ a combination of physical, occupational, and speech therapy; psychological counseling; and social work directed toward helping patients maintain or recover physical capacities (Beer, et al., 1999). The services provided include measures to restore function for activities of daily living (ADLs). These include personal care such as grooming, bathing, dressing, feeding and toileting. The referring physician and rehabilitation team can determine which activities are achievable and essential for the patient to remain independent (Beers, et al., 1999).

In addition to a preadmission screening 48 hours prior to admission, according to CMS the following components must be met in order for inpatient rehabilitation services to be considered medically necessary (CMS, 2010):

- The patient must require the active and ongoing therapeutic intervention of multiple therapy disciplines (physical, occupational, speech-language pathology, prosthetics/orthotics), one of which must be physical or occupational.
- There is a reasonable expectation of measurable improvement that will be of practical value (to improve the patient's functional capacity or adaptation to impairments) within a prescribed period of time.
- The intensive rehabilitation therapy program generally consists of at least three hours of therapy per day at least five days per week; in some circumstance at least 15 hours of intense rehabilitation therapy with a consecutive 7 day period may be considered as an alternative, beginning with the date of admission.
- The patient's plan of care is developed and managed by a coordinated multidisciplinary team including a physician, rehabilitation nurse and one therapist.
- The patient must require physician supervision by a rehabilitation physician, the physician must conduct face-to-face visits with the patient at least three days per week to assess the patient both medically and the functionally, as well as to modify the course of treatment.
- The complexity of the patient's nursing; medical management; and rehabilitation needs require an inpatient interdisciplinary team approach for delivery of care.
- The interdisciplinary team must document participation from all of the following:
    - a rehabilitation physician with specialized training or experience in rehabilitation
    - a registered nurse with specialized training or experience in rehabilitation
    - a social worker and/or case manager
    - a licensed or certified therapist from each therapy involved in treating the patient

Rehabilitation Team and Services
Inpatient acute rehabilitation is an interdisciplinary process that comprises a number of surgical and medical specialties appropriate to the needs of each patient. The overall goal is to help the physically or cognitively impaired to achieve or regain their maximum functional potential for mobility, self-care and independent living, although not necessarily complete independence. The multidisciplinary rehabilitation team is led by a physiatrist (i.e., physician with specialized training and/or experience in physical rehabilitation medicine) and includes other members such as rehabilitation nurses, physical therapists, occupational therapists, speech therapists, neuropsychology, and social workers. Rehabilitation services and treatment provided in an inpatient setting may include any of the following services (this list is not indicative of coverage):

- physical therapy
- occupational therapy
- speech and language pathology
- cognitive assessment and treatment
- psychology
- neuropsychologic testing
- electrodiagnostic testing
- rehabilitative nursing
- social services
- therapeutic nutritional and dietary services
- therapeutic recreation
- prosthetic and orthotic prescription and fitting
- respiratory therapy
- cancer and cardiopulmonary services

Rehabilitative care services are determined by the patient's functional needs, and the availability of resources. Documentation provided in the patient's medical record must support medical necessity and should include relevant medical history, including the patient's rehabilitation potential and prior level of function, physical examination, and results of pertinent diagnostic test or procedures. In addition, the documentation must reflect the ongoing assessment and necessary adjustments to the plan of care.

Current functional status and measurable goals individualized to the needs and abilities of the patient should be part of the plan of care. The patient's progress toward established goals should be reviewed at least weekly and should include objective measurements (e.g., Functional Improvement Measurement [FIM] scores) as well as a clinical narrative which demonstrates functional improvement and progress towards attainable treatment goals as a result of the therapy provided.

Conflicting documentation between disciplines, widely fluctuating patient abilities, or failure to progress as planned should be explained and a realistic plan to address the problem identified. The plan of care should also include documentation of discharge plans.

Care provided during inpatient acute rehabilitation is provided by many disciplines working together in a coordinated method. Documentation should reflect active involvement of each discipline as well as a coordinated team approach in order to meet individualized patient goals.

Discharge planning is an integral part of the rehabilitation program. Discharge from inpatient rehabilitation is appropriate when the patient has achieved the established goals and daily multidisciplinary therapy is no longer required. Inpatient acute rehabilitation is not medically necessary when further progress toward established goals is unlikely or when services can be provided in a less intense setting.

Literature Review
Evidence in the published scientific literature reveals no studies demonstrating superiority of one type of rehabilitative setting over another. However, in general, studies do support improved patient functional outcomes with an organized multidisciplinary approach to rehabilitative care. Few studies have compared functional outcomes for patients admitted to inpatient rehabilitation hospitals, subacute facilities or SNFs. Authors generally agree the patient's medical stability and rehabilitative needs are the most important determinants for the appropriate choice of rehabilitation setting.

Authors of a Cochrane review (Ward, et al., 2004) concluded there is insufficient evidence to compare the effects of care home environments, hospital environments, and own home environments on older persons' rehabilitation outcomes and that comparability of the control groups is very weak. The authors initially reported in 2004 their search identified 99 papers which were considered for inclusion in the review. From those, 12 papers met the intervention inclusion criteria and were assessed to see if they met the Cochrane Effective Practice and Organisation of Care Group (EPOC) study design criteria. None of the papers qualified for inclusion in the review. The review was updated in 2008 when the reviewers reviewed 56 studies and 5 review articles. The results of both reviews indicated that more rigorous studies are required comparing the effects of rehabilitation services in various settings.

Joint Arthroplasty: Authors have reported shorter length of stay and improved functional outcomes for patients who underwent joint arthroplasty and admitted to IRF's compared to SNF's. Typically, IRF's provide more intense rehabilitative services to patients when compared to SNF's. Walsh and Herbold (2006) conducted a retrospective chart review on 87 pairs of patients who were treated in either a skilled nursing facility (SNF) or inpatient rehabilitation facility (IRF) following single hip or knee joint arthroplasty, and concluded that when matched for age, gender, type of surgery and Functional Independent Measure (FIM) score at admission, those patients who received rehabilitation in an IRF had, on average, shorter length of stay and superior functional outcomes. Nonetheless, this study was not randomized, did not have controls, and did not evaluate long-term outcomes. Munin et al. (2005) reported on hip fracture patients who were admitted to either an IRF or SNF for rehabilitation and also concluded that patients admitted to an IRF had shorter length of stay and superior functional outcomes at 12 weeks when compared to patients treated in an SNF. However, both authors suggest further research is needed to determine what factors influence outcomes.

As part of the revised classification criterion for classifying hospitals as inpatient acute rehabilitative facilities, CMS has included knee and hip replacement as a medical condition listed in the regulatory requirements (CMS, 2007). According to the final ruling, patients who require hip or knee joint replacement, or both, during an acute hospitalization immediately preceding an inpatient rehabilitation stay must also meet one of the following criteria for prospective payment:

- The patient underwent bilateral knee or bilateral hip joint replacement surgery during the acute hospital admission immediately preceding the inpatient rehabilitation stay.
- The patient is extremely obese with a body mass index (BMI) of at least 50 at the time of admission to the inpatient rehabilitation facility.
- The patient is age 85 or older at the time of admission to the inpatient rehabilitation facility.

Despite the CMS final rule, authors in the published scientific literature evaluating joint arthroplasty and various multidisciplinary rehabilitation settings do not conclusively agree upon superiority for inpatient acute rehabilitation. Siggeirsdottir et al. (2005) reported that a preoperative education program, followed by postoperative home-based rehabilitation, appears to be safer and more effective in improving function and quality of life after total hip replacement than conventional treatment. Roos (2003) reported that for patients undergoing elective hip and knee arthroplasty, preoperative medical and social conditions are unchanged by the surgical experience, and discharge directly to home, with postacute care as needed, is the preferred destination. In 2002, Naglie et al. conducted a study that consisted of 279 patients who underwent surgical repair for hip fracture. The subjects were randomly assigned to receive either postoperative interdisciplinary care or usual care. They concluded that postoperative inpatient interdisciplinary care did not result in significantly better three- or six-month outcomes in elderly patients with hip fracture.

Khan et al. (2008) conducted a review to evaluate the effect of multidisciplinary rehabilitation programs following hip or knee joint replacement. According to the authors, a total of five randomized controlled trials, all of low quality, were included in the review: two evaluated inpatient rehabilitation (n=261), three evaluated home-based settings (n=358). Pooling of data was not done due to differences in study design and outcomes used. The group of authors reported that multidisciplinary rehabilitation that happens very soon (24 to 48 hours) after a hip or knee replacement may improve an individual's ability to move. For inpatient settings, early rehabilitation and clinical pathways resulted in more rapid attainment of functional goals, shorter hospital stay, and fewer post-operative complications and decreased costs in the first thee to four months. Home-based programs improved functional gains, and reduced hospital stay in the medium term (six months) following hip replacement, although there was no evidence to support this finding following knee replacement. While further studies would be helpful,

there is some evidence to suggest that early multidisciplinary rehabilitation can improve level of activity and participation outcomes following hip and knee replacement.

In a randomized controlled trial, Mahomed and colleagues (2008) evaluated the effectiveness and costs of home-based rehabilitation compared with inpatient rehabilitation for total joint replacement (n=234). All patients followed standardized care pathways and were evaluated using WOMAC scores, Short Form-36, and patient satisfaction prior to surgery and at three (primary outcome) and 12 months following surgery. A total of 119 subjects were randomized to inpatient rehabilitation and 115 were randomized to home-based rehabilitation. Regarding the effectiveness of care, the results of the study demonstrated that there were no differences in clinical outcomes at three and 12 months after surgery; both groups achieved similar improvements in pain and function.

Stroke: The rehabilitative approach to patients who have suffered stroke can be either supportive or active and intensive. Clinical practice guidelines have been established by a joint task force from the Department of Veterans Affairs and the U.S. Department of Defense, endorsed by the Stroke Council of the American Heart Association, to provide evidence-based medical care for patients requiring stroke rehabilitation (Bates, et al., 2005). Most evidence suggests that early intervention and multidisciplinary approaches improve functional outcomes and can reduce long-term care costs. Bates and associates (2005) reported, “Although the literature is clear that organized services are a dominant component of stroke rehabilitation, it is not possible to specify precise standards and protocols for types of specialized services needed. The most common care settings for rehabilitation services are inpatient rehabilitation facilities, nursing homes, outpatient therapy clinics, and home care. No study has demonstrated the superiority of one type of rehabilitation setting over another.” Generally, authors agree that selection of rehabilitation setting is dependent on the patient’s motor and cognitive function, level of endurance, and social support system.

Rehabilitation services are also frequently provided for conditions such as spinal cord injury, congenital deformity, amputations, major multiple trauma, brain injury, neurologic disorders and burns. However, a large percentage of patients may benefit from inpatient rehabilitation after severe medical or surgical conditions such as cardiac surgery, pulmonary disorders, and surgery for cancer conditions. It has been shown in the published scientific literature that organized multidisciplinary rehabilitation improves functional outcomes, although the intensity of prescribed rehabilitative services is based on the patient’s functional needs and the availability of resources.

Authors have also researched factors that are associated with admission to inpatient rehabilitation. These factors have been shown in the literature to include previous functional status, comorbidities, marital status, race, age, gender, sex, presence of obesity, social support, type of surgery and/or injury, and postoperative functional status (Stucki, et al., 2005; Pablo, et al., 2004; Roos, 2003; Munin, et al., 1998).
Recently, Rooks et al. (2006) reported that a six-week presurgical exercise program prior to total joint arthroplasty significantly reduced the odds of admission to an inpatient rehabilitation program by 73%. In their study group of 49 total hip arthroplasties and 29 total knee arthroplasties, a greater portion of nonexercisers (54%) went to inpatient rehabilitation facilities compared to exercisers (33%). Additionally, Lin and Kaplan (2004) studied inpatient rehabilitation length of stay, and reported increased length of stay for similar associated factors.

Summary
Inpatient acute rehabilitation provides intense multidisciplinary services to restore or enhance function postinjury or illness. Organized, multidisciplinary rehabilitative care has been shown to improve functional outcomes in selected groups of patients. Evidence in the peer-reviewed scientific literature has suggested that early identification of rehabilitation needs and early start of rehabilitative services can reduce healthcare costs, length of stay and disability for some patients; however, there have been no studies supporting the superiority of one type of setting over another. The intensity of rehabilitation care is dependent upon the patient’s individual rehabilitative needs and medical stability.

Coding/Billing Information

Note: This list of codes may not be all-inclusive.

Covered when medically necessary:

Revenue Codes†	Description
0128	Room and board, semi-private, two-bed, rehabilitation
0138	Room and board, semi-private, three-four bed, rehabilitation
0158	Room and board, ward, rehabilitation

DRG	Description
945	Rehabilitation with complications and comorbidities/ major complications and comorbidities

ICD-9-CM Procedure Codes	Description
93.11-93.19	Physical therapy exercises
93.21-93.29	Other physical therapy musculoskeletal manipulation
93.31	Assisted exercise in pool
93.32	Whirlpool treatment
93.33	Other hydrotherapy
93.34	Diathermy
93.35	Other heat therapy
93.38	Combined physical therapy without mention of the components
93.39	Other physical therapy
93.72	Dysphasia training
93.74	Other speech training and therapy
93.83	Occupational therapy

ICD-9-CM Diagnosis Codes	Description
357.0	Acute infective polyneuritis
433.01	Basilar artery occlusion and stenosis, with cerebral infarction
433.11	Carotid artery occlusion and stenosis, with cerebral infarction
433.21	Vertebral artery occlusion and stenosis, with cerebral infarction
433.31	Multiple and bilateral occlusion and stenosis of precerebral arteries, with cerebral infarction
433.81	Other specified precerebral artery occlusion and stenosis with cerebral infarction
433.91	Unspecified precerebral artery occlusion and stenosis, with cerebral infarction
434.91	Cerebral artery occlusion, unspecified, with cerebral infarction
438.20-438.22	Late effects of cerebrovascular diseases, hemiplegia/hemiparesis
438.30-438.32	Late effects of cerebrovascular disease, monoplegia of upper limb
438.40-438.41	Late effects of cerebrovascular disease, monoplegia of lower limb
438.50-438.53	Late effects of cerebrovascular disease, other paralytic syndrome
713.0-713.8	Arthropathy associated with other disorders classified elsewhere
714.0-714.9	Rheumatoid arthritis and other inflammatory arthropathies
819.0-819.1	Multiple fractures involving both upper limbs and upper limb with rib(s) and sternum
828.0-828.1	Multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum

851.11-851.99	Cerebral laceration and contusion
852.00-852.59	Subarachnoid, subdural and extradural hemorrhage following injury
853.00-853.19	Other and unspecified intracranial hemorrhage following injury
854.00-854.19	Intracranial injury of other and unspecified nature
887.0-887.7	Traumatic amputation of arm and hand (complete) (partial)
896.0-896.3	Traumatic amputation of foot (complete)(partial)
897.0-897.7	Traumatic amputation of leg(s) (complete) (partial)
905.0	Late effect of fracture of skull and face bones
906.7	Late effect of burn of other extremities
906.8	Late effect of burns of other specified sites
906.9	Late effect of burn of unspecified site
907.0-907.9	Late effect of injuries to the nervous system
942.30-942.39	Burn of trunk, full-thickness skin loss [third degree NOS]
942.40-942.49	Burn of trunk, deep necrosis of underlying tissues [deep third degree] without mention of loss of a body part
942.50-942.59	Burn of trunk, deep necrosis of underlying tissues [deep third degree] with loss of body part
943.30-943.39	Burn of upper limb, except wrist and hand, full thickness skin loss [third degree NOS]
943.40-943.49	Burn of upper limb, except wrist and hand, deep necrosis of underlying tissues [deep third degree] without mention of loss of a body part
943.50-943.59	Burn of upper limb, except wrist and hand, deep necrosis of underlying tissues [deep third degree] with loss of a body part
945.30-945.39	Burn of lower limb(s), full thickness skin loss [third degree NOS]
945.40-945.49	Burn of lower limb(s), deep necrosis of underlying tissues [deep third degree] without mention of loss of a body part
945.50-945.59	Burn of lower limb(s), deep necrosis of underlying tissues [deep third degree] with loss of a body part
952.00-952.9	Spinal cord injury without evidence of spinal bone injury
V54.81	Aftercare following joint replacement
	Multiple/Varied Codes

Not Medically Necessary/Not Covered:

ICD-9-CM Procedure Codes	**Description**
93.81	Recreation therapy
93.82	Educational therapy
93.84	Music therapy
93.85	Vocational rehabilitation

ICD-9-CM Diagnosis Codes	**Description**
V57.22	Encounter for vocational training

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Policy History

Pre-Merger Organizations	Last Review Date	Policy Number	Title
CIGNA HealthCare	2/15/2007	0427	Inpatient Acute Rehabilitation