# CIGNA MEDICAL COVERAGE POLICY

*This Coverage Policy should NOT be used for Great-West benefit plans.*

**Effective Date ..... 2/15/2009**
**Next Review Date ..... 2/15/2010**
**Coverage Policy Number ..... 0441**

**Subject** **Outpatient Acute Rehabilitation**

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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 as well as benefit plans formerly administered by Great-West Healthcare. Please note, the terms of a participant'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 participant'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 participant'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 group 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. Proprietary information of CIGNA. Copyright ©2009 CIGNA*

## Coverage Policy

**Under many benefit plans, coverage for outpatient acute rehabilitation is subject to the terms, conditions and limitations of the applicable benefit plan's Short Term Rehabilitative Therapy benefit and schedule of copayments. Many benefit plans include a maximum allowable benefit for duration of treatment or number of visits. When the maximum allowable benefit is exhausted, coverage will no longer be provided, even if the medical necessity criteria described below are met. Please refer to the applicable benefit plan document to determine benefit availability and the terms, conditions and limitations of coverage. In addition, some plans specifically exclude therapy for learning disabilities, developmental delays, autism, and mental retardation and/or for that which is not restorative in nature.**

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

- The individual requires comprehensive, coordinated, skilled rehabilitation treatment from a multidisciplinary team consisting of at least two therapies (e.g., physical therapy, occupational therapy, speech therapy).
- The individual is medically stable and is capable and willing to participate in intensive therapy for several hours per day, three to 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.

- Rehabilitation is not required in an inpatient rehabilitation facility due to BOTH of the following conditions:
    - The individual does not require 24-hour-a-day access to a registered nurse with specialized training in rehabilitation care.
    - The individual does not require frequent rehabilitation team assessment and/or intervention due to the potential risk of significant change in physical or medical status.

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

**CIGNA covers intensive rehabilitation in the home (e.g., Gentiva Rehab Without Walls®) when the above criteria are met and the individual meets medical necessity criteria for care to be provided in the home. Under many benefit plans, coverage for outpatient multidisciplinary rehabilitation provided in the home setting is subject to the terms, conditions and limitations of the applicable benefit plan's Short Term Rehabilitative Therapy benefit and schedule of copayments.**

**CIGNA does not cover outpatient acute rehabilitation for ANY of the following circumstances because it is either considered not medically necessary when used for these indications or because it is excluded from many benefit plans:**

- when the individual's condition is such that it would be medically appropriate to receive services in a less intensive setting (e.g., nonacute outpatient program, home)
- when coordinated multidisciplinary care is not provided or required
- when documentation in the medical record does not support the need for outpatient acute rehabilitation
- services to prevent or slow deterioration in function or prevent reoccurrences
- services to improve general physical condition or for long-term rehabilitative services when significant improvement is not expected (i.e., maintenance therapy)
- services for the purpose of enhancing athletic performance or for recreation

**CIGNA does not cover outpatient acute rehabilitation for ANY of the following because each is considered nonmedical, educational, or training in nature and thus is not medically necessary. In addition, these programs are specifically excluded under many benefit plans:**

- vocational rehabilitation programs and any programs with the primary goal of returning an individual to work
- group rehabilitation
- work hardening programs

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## General Background

According to the U.S. Census Bureau 2000 census, 49.7 million people age five and over have at least one disability; a ratio of nearly 1 in 5 U.S. residents. Rehabilitation is a restorative process to maximize a patient's functional ability. It is performed in a wide variety of settings, and is carried out by a variety of people. Rehabilitation is the primary means of treating disability.

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 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.

Outpatient 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 should 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. Outpatient acute services may be provided in a freestanding rehabilitation hospital, a comprehensive outpatient rehabilitation facility (CORF), or an acute care hospital. When medically necessary, rehabilitation may also be provided in the home setting as an alternative to outpatient acute rehabilitation. This type of rehabilitation provides a multidisciplinary approach to improving the functional skills necessary to perform daily activities while in the patient's own environment (i.e., home). Multidisciplinary rehabilitation provided in the home may be beneficial to a patient who requires both home care and an intense multidisciplinary approach to rehabilitation.

Outpatient acute services are an alternative to acute inpatient rehabilitation, and may be referred to as partial hospital day treatment programs, or day rehabilitation programs. These services are provided to patients who require intense multidisciplinary treatment but not 24-hour care. The program enables the patient to live at home while maintaining access to an interdisciplinary team and rehabilitative equipment. Typically, the patient spends several hours, three to five days per week, in an outpatient acute or hospital day program. Intense outpatient rehabilitative programs require the patient's independent transportation to and from the facility, unless provided in a home setting.

Admission to a program is dependent on the patient's clinical needs. The services provided should be accepted as standards of medical practice that are specific and effective treatment for the condition, and should be provided at a level of complexity that requires it be performed by a qualified therapist, or the patient's condition requires the skills of a therapist, and there is expectation of improvement over a reasonable amount of time. Services that are unskilled, custodial, of unproven benefit, considered palliative in nature, considered maintenance, or are performed by staff without qualifications are generally not medically necessary.

The following table summarizes the range of settings for which rehabilitation may be provided, as well as general criteria for patients cared for in these settings (Warshaw, 1999):

| Settings | Characteristics |
|---|---|
| Comprehensive Inpatient Medical Rehabilitation | |
| • Category I (acute) Hospital | • High risk for medical instability; requires two or more disciplines; generally three hours of therapy a day; Medicare coverage same as for other types of acute hospitalization |
| • Category 2 (subacute) Hospital, Hospital-based skilled nursing facility (Hospital-based SNF), SNF | • Moderate risk for medical instability, requires two or more disciplines, generally three hours of therapy a day, Medicare coverage varies |
| • Category 3 (subacute) Hospital-based SNF, SNF | • Low risk for medical instability, skilled therapy five times a week, less than three hours per day, one or more disciplines, Medicare covers 20 days in full and 21 days to 100 partially |
| Home care program | Patient is homebound, single or multiple therapies required, adequate social supports required, limited Medicare coverage |
| Outpatient CORF (comprehensive outpatient rehabilitation facility) | Complexity requires interdisciplinary process, multiple disciplines, adequate social resources, limited Medicare coverage |
| Individual therapies | Limited number of disciplines, less complex cases, adequate social resources required, limited Medicare coverage |

**Rehabilitation Team and Available Services**

The multidisciplinary team includes members such as physical therapists, occupational therapists, and speech-language therapists in addition to rehabilitation nurses and social workers. During intense outpatient rehabilitation, the rehabilitation services are provided at a single location in a coordinated fashion. 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 available services involve a comprehensive multidisciplinary team approach of providing skilled rehabilitation, which may include any of the following services:

- Physician services: The professional services that are performed by physicians include consultations and home, office and institutional evaluation and management services rendered by a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs the services.

- Physical therapy: Physical therapy services may include testing, measurement, assessment and treatment of function or dysfunction of the neuromuscular, musculoskeletal, cardiovascular and respiratory system, and establishment of a maintenance therapy program for an individual whose restoration potential has been reached.

- Social or psychological services: Social services include assessment of the social and emotional factors related to the individual's illness, requirements for care, response to treatment, adjustment to care furnished; casework services to assist in resolving social or emotional problems that may have an adverse effect on the patient's ability to respond to treatment, and assessment of the relationship of financial resources, and the community resources available upon discharge. Psychological services may include assessment, diagnosis, and treatment of the individual's mental and emotional functioning as it relates to the person's rehabilitation, psychological evaluations of the person's progress under the treatment plan, and assessment of those aspects of the patient's family and home situation that affect their rehabilitation treatment.

- Occupational therapy: Occupational therapy services include assessment of the individual's level of independent functioning, selection and teaching of task-oriented therapeutic activities to permit an individual with a physical or cognitive impairment or limitation to engage in daily activities.

- Speech therapy: Speech-language therapy services typically consist of the diagnosis and treatment of speech and language disorders that create difficulties in communications or dysphagia.

- Respiratory therapy: Respiratory therapy services include the functional assessment, diagnosis, and treatment of patients with deficiencies or abnormalities of cardiopulmonary function.

- Prosthetic and orthotic devices: Services for prosthetic and orthotic devices typically includes testing, fitting, or training in the use of such devices.

- Nursing services: Nursing services include those services specific to the plan of treatment and any other nursing services necessary for the attainment of the rehabilitation goals which are provided by or under the direct supervision of a professional registered nurse.

- Pharmaceuticals and biologics: Services may include pharmaceuticals and biologics which are not usually self-administered by the patient.

Rehabilitative care services are determined by the patient's functional needs and the availability of resources. Documentation provided in the patient's medical record should 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 should reflect the ongoing assessment and necessary adjustments to 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 independence measure [FIM] scores) as well as a

clinical narrative which demonstrates functional improvement and progress toward 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.

**Physician Referral**
In order for a patient to receive outpatient acute rehabilitation services, the patient should be under the care of a physician who certifies that the patient needs and can tolerate a program of intensive skilled rehabilitation. In addition, the physician should furnish a detailed treatment plan constructed after consultation with the treating physical therapist(s), occupational therapist(s), nurse(s), and/or speech-language therapist(s). The treatment plan should include the patient's diagnosis, the type, amount, duration and frequency of the skilled rehabilitation services being proposed and established goals. The treatment plan should provide adequate detail on the specific need for the skilled service and of the potential benefit the patient will receive. Documentation should reflect active involvement of each discipline, as well as a coordinated team approach in order to meet individualized patient goals. The treatment plan should be reviewed at least weekly and should document progress toward the established goals. Once established goals for treatment have been met, or when there is no further progress, intense outpatient rehabilitation therapy is no longer medically necessary.

**Literature Review**
Rehabilitation interventions are considered clinically appropriate for several conditions that result in functional impairment such as stroke, musculoskeletal disorders, amputations, hip fractures, cardiac conditions and pulmonary conditions. Evidence in the published scientific literature does not demonstrate superiority of one type of rehabilitative setting over another. However, in general, studies do support improved functional outcomes with an organized multidisciplinary approach to rehabilitative care. The patient's medical stability and rehabilitative needs are the most important determinants for the appropriate choice of rehabilitation setting.

In 2007, the Centers for Disease Control and Prevention (CDC) reported on data from the 2005 Behavioral Risk Factor Surveillance System (BRFSS) on stroke survivors in 21 states and the District of Columbia. The assessment indicated that 30.7% of stroke survivors received outpatient rehabilitation and a higher prevalence of outpatient stroke rehabilitation was reported among men, non-Hispanic blacks, unemployed or retired adults, and persons living in the center city of a metropolitan statistical area than in comparison groups. According to the CDC, the prevalence of those receiving services was lower than expected if clinical practice guidelines for all stroke patients had been followed. Recent guidelines recommend outpatient rehabilitation for stroke patients who have been recently discharged from inpatient rehabilitation and for less severely disabled patients who have been discharged after receiving acute stroke care. The CDC acknowledged increasing the number of stroke survivors who receive outpatient rehabilitation may lead to better functional status and quality of life in this population (CDC, 2007). Nonetheless, some of the report limitations as noted by the CDC included lack of information regarding inpatient rehabilitation or referral, lack of nationwide estimates, obtaining self-reported outcomes, and low response rate to the questionnaire.

Several Cochrane reviews have been published addressing intense multidisciplinary rehabilitation in various settings and for various conditions. Khan et al. (2007) published a review of eight randomized clinical trials in total, assessing organized multidisciplinary rehabilitation in adults with multiple sclerosis and found that there was limited evidence for short-term improvements in symptoms and disability with high-intensity programs. According to the authors, this translated into improvement in participation and quality of life. For low-intensity programs over longer periods of time, there was strong evidence for longer-term gains in quality of life, and limited evidence for benefits to caregivers. It was not possible for the authors to suggest a "best dose" therapy or that one type of therapy was better when compared to another.

Ashworth et al. (2005) assessed the effectiveness of home-based versus center-based physical activity programs and the health of older adults. The Cochrane authors reviewed six trials, including 224 participants who received a home-based exercise program and 148 who received a center-based exercise program. The selected study participants were required to have either a cardiovascular risk factor or existing disease, chronic obstructive pulmonary disease (COPD), or osteoarthritis. The authors concluded that, overall, there is evidence that both exercising at home and at centers improves the health and physical function of older adults, and that people tend to comply with exercising at home more than in a center. People with heart disease show more improvements when exercising at a center than at home in the short-term (i.e., three months). Based on the studies reviewed, in people with COPD, it is not clear which exercise program is better. Furthermore, studies are

needed to test which program is better for patients with osteoarthritis, since there were no studies of this patient population available.

Turner-Stokes et al. (2005) assessed multidisciplinary rehabilitation in patients following acquired brain injury (ABI) in an adult population and reported that intensive intervention appears to lead to earlier improvement and that patients discharged from inpatient rehabilitation centers should have access to outpatient or community-based services which are appropriate for their needs. Patients with milder brain injury benefit from follow-up, appropriate information and advice.

An earlier 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 reported their search identified 99 papers considered for inclusion in the review. From those, 12 papers met the intervention inclusion criteria and were assessed to determine if they met the Cochrane Effective Practice and Organization of Care Group (EPOC) study design criteria. None of the papers qualified for inclusion in the review. They concluded that more rigorous studies are required comparing the effects of rehabilitation services in various settings.

**Summary**
Outpatient acute rehabilitation provides comprehensive, multidisciplinary services to restore or enhance function post-injury or illness for patients who do not require 24-hour care. Organized, multidisciplinary rehabilitative care has been shown to improve functional outcomes in selected groups of patients. Evidence in the peer-reviewed, scientific literature suggests that early identification of rehabilitation needs and early start of rehabilitation services can reduce health-care costs, length of stay and disability for some patients; however, the evidence does not support 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.

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## Coding/Billing Information

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

**Covered when medically necessary:**

| **CPT®* Codes** | **Description** |
|---|---|
| 92506 | Evaluation of speech, language, voice, communication and/or auditory processing |
| 92507 | Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual |
| 97001 | Physical therapy evaluation |
| 97002 | Physical therapy re-evaluation |
| 97003 | Occupational therapy evaluation |
| 97004 | Occupational therapy re-evaluation |
| 97010 | Application of a modality to one or more areas; hot or cold packs |
| 97012 | Application of a modality to one or more areas; traction, mechanical |
| 97014 | Application of a modality to one or more areas; electrical stimulation (unattended) |
| 97016 | Application of a modality to one or more areas; vasopneumatic devices |
| 97018 | Application of a modality to one or more areas; paraffin bath |
| 97022 | Application of a modality to one or more areas; whirlpool |
| 97024 | Application of a modality to one or more areas; diathermy (eg,microwave) |
| 97026 | Application of a modality to one or more areas; infrared |
| 97028 | Application of a modality to one or more areas; ultraviolet |
| 97032 | Application of a modality to one or more areas; electrical stimulation (manual), each 15 minutes |

| | |
|---|---|
| 97033 | Application of a modality to one or more areas; iontophoresis, each 15 minutes |
| 97034 | Application of a modality to one or more areas; contrast baths, each 15 minutes |
| 97035 | Application of a modality to one or more areas; ultrasound, each 15 minutes |
| 97036 | Application of a modality to one or more areas; Hubbard tank, each 15 minutes |
| 97110 | Therapeutic procedure, one or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility |
| 97112 | Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities |
| 97113 | Therapeutic procedure, one or more areas, each 15 minutes; aquatic therapy with therapeutic exercises |
| 97116 | Therapeutic procedure, one or more areas, each 15 minutes; gait training (includes stair climbing) |
| 97124 | Therapeutic procedure, one or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion) |
| 97140 | Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), one or more regions, each 15 minutes |
| 97530 | Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes |
| 97535 | Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact by provider, each 15 minutes |
| 97760 | Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity (s), lower extremity(s) and/or trunk, each 15 minutes |
| 97761 | Prosthetic training, upper and/or lower extremity(s), each 15 minutes |

| **HCPCS Codes** | **Description** |
|---|---|
| G0129 | Occupational therapy requiring the skills of a qualified occupational therapist, furnished as a component of a partial hospitalization treatment program, per day |
| G0151 | Services of physical therapist in home health setting, each 15 minutes |
| G0152 | Services of occupational therapist in home health setting, each 15 minutes |
| G0153 | Services of speech and language pathologist in home health setting, each 15 minutes |
| S9128 | Speech therapy, in the home, per diem |
| S9129 | Occupational therapy, in the home, per diem |
| S9131 | Physical therapy; in the home, per diem |

| **ICD-9-CM Diagnosis Codes** | **Description** |
|---|---|
| V57.1 | Other physical therapy |
| V57.21 | Encounter for occupational therapy |
| V57.3 | Speech therapy |
| | Multiple/varied codes |

**Not Medically Necessary/Not Covered:**

| **CPT* Codes** | **Description** |
|---|---|
| 92508 | Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals |
| 97150 | Therapeutic procedure(s), group (2 or more individuals) |
| 97005 | Athletic training evaluation |
| 97006 | Athletic training re-evaluation |

| | |
|---|---|
| 97537 | Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact by provider, each 15 minutes |
| 97545 | Work hardening/conditioning; initial 2 hours |
| 97546 | Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure) |

| **HCPCS Codes** | **Description** |
|---|---|
| S8990 | Physical or manipulative therapy performed for maintenance rather than restoration |

| **ICD-9-CM Diagnosis Codes** | **Description** |
|---|---|
| V57.22 | Encounter for vocational therapy |
| | Multiple/Varied codes |

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