Policy	MM-0114
Effective Date	**08/01/2026**
Reviewed/Revised Date	08/10/2026
Next Review Date	08/10/2027
Origination Date	08/01/2026
Originated Department	Medical Management

Inpatient Rehabilitation Facilities- Post Acute Care (PAC)

Purpose

Medical policies provide general support for applying Mountain Health Co-Op member policy document coverage decisions, and the member-specific benefit plan document must be referenced. The terms of the member-specific Policy document may differ from the standard benefit plan based on this medical policy. If there is a conflict between a member-specific policy document and the Mountain Health Co-Op medical policy, the document supersedes this policy. Any person(s) applying this medical policy must identify member eligibility, the member-specific policy document, and related policies or guidelines before applying this medical policy, including the existence of any state or federal guidance. Mountain Health Co-Op medical policies are designed for informational purposes only and are not an authorization, explanation of benefits, or contract. Receipt of benefits is subject to the satisfaction of all terms and conditions of the member-specific policy document coverage. Mountain Health Co-Op reserves the sole discretionary right to modify all policies and guidelines at any time

Definition

- **Functional impairment** – A mobility, self-care, cognitive and/or behavioral-related impairment which has been determined via a comprehensive, skilled assessment of the patient's clinically significant activities on at least one validated functional measure.
- **Skilled Nursing Facility (SNF)** – An inpatient facility providing skilled nursing with or without rehabilitative care and classified by CMS as a SNF. Typically, it provides such care on a less than long-term basis and may be free-standing or contained within another medical institution such as a nursing home or acute care hospital. It is traditionally considered the lowest level of facility-based post-acute care, though this may vary depending on the individual facility's characteristics.
- **Inpatient Rehabilitation Facility (IRF)** – An inpatient facility providing high-intensity, multi-disciplinary rehabilitative care coordinated by a rehabilitation physician. IRFs are commonly freestanding but may be contained within an acute care hospital. IRFs are traditionally considered the highest level of rehabilitative post-acute care and intended for patients whose care needs are primarily rehabilitative. Also commonly referred to as "Acute Rehab" or "Acute Inpatient Rehab."

- **Long Term Acute Care Hospital (LTACH)** – An inpatient facility providing medical and rehabilitative care for patients whose medical care needs exceed their rehabilitative care needs and who are expected to require an extended course of medical treatment relative to an acute care hospital (extended course typically expected to be 25 days). Also commonly referred to as Long Term Acute Care (LTAC) or Long-Term Care Hospital (LTCH).

Policy/Procedure

Staffing requirements of Inpatient Rehabilitation for Admission

Facility Director: The Facility Director must possess appropriate academic credentials and administrative experience in adult, child, and adolescent medical-surgical rehabilitative services. The Facility Director is typically responsible for the fiscal and administrative support of the facility's clinical program.

Medical Director: The facility must be overseen by a Board-Certified Medical Director (MD/DO) in the area in which the facility treats patients, such as Physical Medicine and Rehabilitation. CMS allows for some flexibility in the credentials and broadly defines the rehabilitation physician as "*a licensed physician with specialized training and experience in inpatient rehabilitation*." This requires *"a one-year hospital internship, at least 2 years of training or experience in the medical-management of inpatients requiring rehabilitation". The Medical Director provides services on a full-time basis or at least 20 hours per week for a distinct part of the rehabilitation unit and must act as the designated rehabilitation physician. (42 CFR § 412.29)*

Interdisciplinary Team must document participation by professionals from each of the following disciplines (each of whom must have current knowledge of the patient as documented in the medical record at the IRF):

- A rehabilitation physician who is determined by the IRF to have specialized training and experience in inpatient rehabilitation;
- A registered nurse with specialized training or experience in rehabilitation;
- A social worker or a case manager (or both); and
- A licensed or certified therapist from each therapy discipline involved in treating the patient.

Facility Accreditation
Accredited by and remain current and in good standing with one of the following organizations: CARF, JCAHO, CMS, or another body approved by MHC.

Prior Authorization Turnaround Times Mountain Health Co-Op follows standard and expedited NCQA turnaround times

Reauthorizations: Reauthorizations must be submitted at least seven days before the current authorization expires, accompanied by the following documentation:

- an updated treatment plan,

- a detailed discharge plan,
- a weekly clinical summary with an updated treatment plan
- documentation demonstrating the member continues to be actively engaged in all aspects of the treatment

  ***Length of authorization:** Up to 60 days maximum

***Mountain Health Co-Op covers services provided in an inpatient rehabilitation facility when the member and facility meet minimum standards**.*

1. Prior Authorization Requirements

Prior authorization for the Inpatient Rehabilitation Facility must be determined before admission. Concurrent review for bed days is required. Submit medical records 7 days before the authorization ends for timely review. Failure to obtain authorization may result in claim denial.

A. Preadmission Screening

A completed preadmission screening is required before IRF admission.

The screening must:

1. Be completed by a licensed or certified clinician within 48 hours immediately before admission; **OR**
2. If completed more than 48 hours before admission, include a documented update (in person or by telephone) within the 48 hours immediately preceding admission.
3. If a member is being directly admitted to an IRF, a referral from an outpatient contracting provider (see criteria below) must be submitted to be considered a valid prior authorization. A referral from the submitting IRF is not valid. If the member is being stepped down from another level of care, the referral may be from the admitting facility. If a member is stepping down within the same facility or transferring to a new facility for a lower level of care after successfully completing a higher level, no external referral is required. Referrals are only necessary for new admissions to the facility.
4. Preadmission screening to the IRF must document **all of** the following:
   a) Prior level of function (Prior to the event or condition that led to the patient's need for intensive rehabilitation therapy)
   b) Current medical and functional status
   c) Diagnosis (ICD-10) is most consistent with the symptoms and behaviors that precipitate the request for an inpatient residential facility and the need for admission to the IRF.
   d) Expected treatments and additional services needed (physical therapy, occupational therapy, speech and language therapy, prosthetics/orthotics, case management, dietitians, etc.)
   e) Risk for medical or clinical complications
   f) Expected functional level of improvement
   g) Estimated length of stay or time to achieve return to prior level of function

5. Required therapy disciplines **(Requires two or more disciplines, one must be physical or occupational therapy):**
   a) Physical therapy (PT) or Occupational therapy (OT)
   b) Speech-language pathology (SLP), when indicated

c) Prosthetics/orthotics, when indicated

6. Need for specialized equipment* to **(Must meet ALL)**
   a) Optimize functional outcomes
   b) Avoid or minimize complications of inappropriate equipment (resulting in additional/extended care needs)
   c) Optimize safety of patient and therapist during treatment (e.g., body weight supported gait training apparatus, tilt table)
   d) Minimize need for medications during treatment (e.g., enclosure beds and other non-pharmacological restraints for fall prevention in agitated patients)
   ***Note:** Specialized equipment refers to equipment generally available only in the IRF and/or requiring the expertise of the IRF staff to employ appropriately*

7. Active Medical Management* during the course of rehabilitation due to a reasonable expectation of the following:
   a) Medical stability will be at risk with resumption/progression of activity
   b) Patient will have specialized medical needs related to rehab condition
   c) Such management will be necessary to maximize participation in therapies and optimize outcomes most efficiently
   d) Such management will minimize and simplify medication regimens
   e) Such management will facilitate discharge to community at higher level of independence (e.g., earlier decannulation or PEG removal, definitive long-term neurogenic bowel/bladder program,)

Active Medical Management generally requires direct physician monitoring, involvement, or intervention for medical issues at least 3 days per week

8. **Overall Plan of Care**
   The information from the preadmission screening and other information garnered from the assessments of all therapy disciplines involved in treating the patient and other pertinent clinicians, must be synthesized by a rehabilitation physician to support a documented overall plan of care.

   The overall plan of care should generally detail the patient's medical prognosis and the anticipated interventions, functional outcomes, and discharge destination from the IRF stay, thereby supporting the medical necessity of the admission.

   The anticipated interventions detailed in the overall plan of care should generally include the:

   a. Expected intensity (number of hours per day),
   b. Frequency (number of days per week), and
   c. Duration (total number of expected IRF days) of physical, occupational, speech-language pathology, and prosthetic/orthotic therapies required by the patient during the IRF stay.

B. Source Documentation

For patients transferring from an acute care hospital:

9. The screening may be completed through review of the referring hospital's medical records if sufficient information is available.
10. Telephone screenings should include review of transmitted medical records whenever possible.

For patients admitted from home or the community:

11. The screening must include all required clinical and functional assessments.
12. Prior hospitalization records are required only when clinically relevant.

C. Rehabilitation Physician Review

Before admission **(Must meet ALL):**

13. All preadmission findings must be reviewed by a rehabilitation physician.
14. The rehabilitation physician must document they agree with the admission decision.
15. All screening documentation must be retained in the IRF medical record.

2. Admission Criteria

Admission to an IRF is medically necessary when **all of** the following criteria are met. **(Must Meet ALL)**

A. Multiple Therapy Disciplines

The member requires active and ongoing treatment from **two or more** therapy disciplines, including:

1. Physical therapy or occupational therapy*; and
2. One or more additional disciplines as clinically indicated:
    a) Occupational therapy
    b) Physical therapy
    c) Speech-language pathology
    d) Prosthetics/orthotics

Patients requiring only one therapy discipline do not require IRF-level care.

One of the disciplines must be physical or occupational therapy.

B. Intensive Rehabilitation Program

3. The member requires intensive rehabilitation demonstrated by either **(Must meet at least 1 of 2):**
    a) At least 3 hours of therapy per day for 5 days per week, or
    b) At least 15 hours of therapy within a consecutive 7-day period beginning on the date of admission.

Additionally:

a) Therapy must begin within 36 hours of admission.
b) Therapy should primarily be individualized (one-on-one).
c) Group therapy is appropriate *only* when documented as clinically indicated.

C. Ability to Participate (Must meet ALL):

4. The member is reasonably expected to:
    a) Actively participate in intensive rehabilitation; and
    b) Tolerate the prescribed therapy intensity.

D. Expected Functional Improvement

5. Documentation must demonstrate a reasonable expectation that the members will **(Must meet ALL):**
   a) Make measurable functional gains;
   b) Achieve clinically meaningful improvement within a reasonable timeframe; and
   c) Benefit from IRF-level rehabilitation.

6. The member is not required to:
   a) Return to prior functional status; or
   b) Achieve complete independence in self-care.

E. Physician Supervision

7. The member requires ongoing medical management by a rehabilitation physician.

Requirements include:

   a) Face-to-face physician visits at least three times per week.
   b) During the first week, all three visits must be completed by the rehabilitation physician.
   c) Beginning in week two, one of the three required weekly visits may be completed by a qualified non-physician practitioner acting within state scope-of-practice requirements.

8. Each visit must assess:
   a) Medical status
   b) Functional progress
   c) Treatment response
   d) Need for plan-of-care modifications

F. Interdisciplinary Team Approach

The member requires coordinated care from an interdisciplinary rehabilitation team.

9. Interdisciplinary Team Requirements

a) The interdisciplinary team must include **(Must meet ALL):**

I. Rehabilitation physician
II. Rehabilitation nurse
III. Social worker and/or case manager
IV. Licensed therapist from each discipline actively treating the member

b) The team must **(Must meet ALL):**

V. Meet at least weekly
VI. Be led by the rehabilitation physician (in person or remotely)
VII. Review progress toward goals
VIII. Address barriers to progress
IX. Revise treatment goals when indicated
X. Update discharge planning

c) Meeting documentation should include **(Must meet ALL):**

i. Participants

ii. Clinical decisions
iii. Treatment plan revisions
iv. Physician agreement on the treatment plan, discharge plan, and clinical decisions which are documented in the medical record.

3. Ongoing Medical Necessity

a) Continued IRF stay is medically necessary when documentation demonstrates **all of** the following **(Must meet ALL):**
b) **All criteria for admission to IRF continue to be met**
   i. Therapeutic goals have been established and documented
   ii. There is at least **ONE** remaining functional therapeutic goal which:
      2.2.1 Is likely attainable in a reasonable and predictable timeframe
      2.2.2 Is reassessed at least weekly
      2.2.3 Will meaningfully improve patient's functional independence and/or safety
   iii. Patient has demonstrated good tolerance of and consistent, meaningful participation in all therapies
   iv. A discharge plan has been formulated and, to the extent possible, executed contemporaneously during stay (so as not to extend stay unnecessarily)
   v. Continued need for intensive rehabilitation services
   vi. Continued need for an interdisciplinary team approach
   vii. Active participation in treatment
c) Ongoing measurable functional improvement through documented functional tools
   i. CMS Section GG
   ii. CARE Tool
   iii. Functional Balance Scale
   iv. Timed up and Go
   v. Six-Minute Walk Test
d) Continued physician oversight
e) Therapy emphasis should gradually transition toward:
f) Caregiver training
g) Durable medical equipment (DME) training
h) Home safety
i) Community reintegration
j) Discharge preparation

4. Brief Exceptions to Therapy Intensity

a) A temporary interruption in therapy (generally no more than three consecutive days) does not automatically invalidate medical necessity when: **(Must meet ALL):**
   i. The interruption is due to an unexpected medical event; and
   ii. The reason is clearly documented.

   Examples include:
   - Diagnostic testing
   - Surgical procedures
   - Chemotherapy or blood product infusions
   - Medically required bed rest
   - Transportation-related fatigue

- Other medically necessary interruptions

5. Reauthorization Requirements (Must meet ALL):
Reauthorization requests must be submitted at least seven calendar days before the current authorization expires.

Documentation must include:

- Updated treatment plan
- Weekly clinical summary
- Current functional progress
- Evidence of active participation in therapy
- Updated discharge plan

Exclusions/Not Medically Necessary
IRF facility care will be considered **Not Medically Necessary** when:

a) There is no reasonable expectation of progression (or further progression) toward goals
   i. Example for Initial Admission:
   ii. There is a cognitive condition such as dementia that is likely to preclude effective learning and carryover, but goals depend on such abilities
   iii. Examples for Ongoing Care:
      10.3.1 Patient is at his/her pre-hospitalization functional baseline
      10.3.2 Identified caregivers are unwilling or unable to provide the necessary care for patients whose goals depend on caregiver involvement
      10.3.3 Caregiver is unavailable or unable to participate in the education and training with the patient as needed to achieve therapeutic goals

b) Discharge is delayed due to pending home modifications that are not required in order to accommodate the patient safety upon discharge or that cannot be completed within a reasonable time relative to meeting therapeutic goals
   Examples:
   - Widening the front door when there is another viable door for patient's entry/exit
   - Taking extra time to install a permanent concrete ramp when a temporary, safe ramp can be installed quicker
   - Contractor is not available to work on a home modification for at least another week
      - Members who cannot or refuse to participate (due to their behavioral, cognitive, or emotional status) or who cannot tolerate the intensity of an RTC program
      - Members who require primarily social, custodial, recreational, or respite care
      - Members who are persistently non-compliant
      - Members who do not participate in active treatment
      - Members whose plan of care does not support the need for active treatment
      - Court-ordered care
      - Services otherwise do not meet clinical criteria outlined above

<u>Noncovered Services</u>

- Any facility considered/described to be a luxury facility is not a covered service
- Any facility that describes itself as a luxury rehab facility or retreat.
- Facility may include therapy services such as acupuncture, art therapy, cooking, sports, equine, beaches, spas/massage.
- Meals, self-administered medications, and transportation
- Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature
- Daycare programs, which include, but are not limited to, those that provide primarily social, recreational, or diversional activities, custodial, or respite care.
- Vocational training when the services are related solely to specific employment opportunities, work skills, or work settings.
- Therapies not based on established medical guidelines, nationally recognized criteria such as the American Academy of Physical Medicine and Rehabilitation (AAPM&R) or other nationally recognized guidelines that pertain to the patient's illness and disease.
- Vocational or religious counseling
- Consciousness raising
- Testing or treatment for learning disabilities
- Activities primarily for educational purposes
- Marriage counseling
- Assertiveness training
- Assertiveness training
- Cognitive training
- Primal therapy
- Bioenergetic therapy
- Obesity control therapy
- Sleep therapy
- Dance therapy, Music or art therapy
- IQ testing, except as a component of individualized, medically necessary psychological/neuropsychological evaluation
- Socialization, delinquency or custodial care services
- Stress reduction classes
- Pastoral counseling
- Acupuncture, acupressure, massage therapy, Rolfing®, homeopathic or naturopathic remedies
- Self-care or self-help training
- Inpatient confinement for environmental change or similar treatment
- Dream therapy
- Recreational therapy
- Equine or other animal therapy
- Wilderness programs or Adventure therapy
- Bright light therapy
- Any other techniques that are not supported by scientific evidence and the medical necessity criteria

Maximum authorization period:
Up to 60 days

Administrative Requirements
Mountain Health Co-Op follows NCQA standards for:

- Standard prior authorization turnaround times
- Expedited prior authorization turnaround times

Vendors

- **Third Party Administrator (TPA)**
- **Medical Management**

References

1. Centers for Medicare & Medicaid Services, Medicare Benefit Policy Manual: Chapter 1 - Inpatient Hospital Services Covered Under Part A; Section 110 - Inpatient Rehabilitation Facility (IRF) Services. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/bp102c01.pdf 2.
2. Centers for Medicare & Medicaid Services, Medicare Learning Network. Inpatient Rehabilitation Facility (IRF) Medical Review Changes, MLN Matters Number: SE17036 Revised. https://www.cms.gov/sites/default/files/repo-new/26/se17036_0.pdf
3. Centers for Medicare & Medicaid Services, Medicare Learning Network. Internet Only Manual Updates to Publication (Pub.) 100-02 to Implement Updates to Policy and Correct Errors and Omissions (Inpatient Rehabilitation Facility (IRF)), MLN Matters Number: MM12353 https://www.cms.gov/files/document/mm12353.pdf
4. Centers for Medicare & Medicaid Services, Medicare Learning Network. Internet Only Manual Updates to Publication (Pub.) 100-02 to Implement Updates to Policy and Correct Errors and Omissions (Inpatient Rehabilitation Facility (IRF)), MLN Matters Number: MM12364 https://www.cms.gov/files/document/mm12364.pdf
5. Centers for Medicare & Medicaid Services, Inpatient Rehabilitation Facilities https://www.cms.gov/medicare/health-safety-standards/certification-compliance/inpatientrehabilitation-facilities
6. Centers for Medicare & Medicaid Services, Medicare Learning Network (MLN) Booklet, Inpatient Rehabilitation Facility (IRF) Reference Booklet: https://www.cms.gov/files/document/inpatientrehabilitationfacilityrefbooklet2pdf 7. Centers for Medicare & Medicaid Services, Inpatient Rehabilitation Facility (IRF) Reference Booklet https://www.cms.gov/files/document/inpatientrehabilitationfacilityirfbookletprintfriendly2pdf
7. GovInfo.com, Code of Federal Regulations (CFR). Basis of Payment: Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units. Title 42; Volume 2; Section 412.622. Issued October 1, 2021. https://www.govinfo.gov/content/pkg/CFR-2021-title42-vol2/pdf/CFR-2021-title42-vol2-sec412-622.pdf

Review/Revision/Approval History

Date	Description
08/01/2026	**New Policy**
08/10/2026	**Reviewed and Approved by the Policy Committee**

Disclaimer

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult appropriate healthcare providers for medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines, and payment guidelines are applied. Benefits are determined by the member's benefit plan, effective when services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Including or excluding a procedure, diagnosis, or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as they apply to an individual member.

Mountain Health Co-Op makes no representations and accepts no liability regarding the content of any external information cited or relied upon in this policy. Mountain Health Co-Op updates its Coverage Policies regularly and reserves the right to amend these policies and give notice per State and Federal requirements. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from Mountain Health Co-Op.

"Mountain Health Co-Op" and its accompanying logo and marks are protected and registered trademarks of Mountain Health Co-Op. The content of this Service is proprietary and protected by copyright. You may access the copyrighted content of this Service only for purposes outlined in these Conditions of Use.