

MOJAVE CREST ASSURANCE COMPANY		MEDICAL POLICY	
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Inpatient Rehabilitation Services — Medical Necessity Criteria

1. PURPOSE

This policy establishes Mojave Crest Assurance Company (MCA) medical necessity criteria for inpatient rehabilitation services rendered in an acute inpatient rehabilitation facility (IRF) or a designated rehabilitation unit of an acute care hospital. These criteria apply to initial admission, continued stay, and discharge determinations for Vista Access PPO members.

2. SCOPE

This policy applies to all utilization review decisions — prior authorization requests, concurrent review, and retrospective review — for inpatient rehabilitation services billed under revenue codes 0118, 0128, 0138, or 0148. Clinical reviewers must apply the version of this policy in effect on the date of service, not the current version.

3. DEFINITIONS

Functional Independence Measure (FIM): An 18-item validated assessment tool measuring functional ability across motor and cognitive domains. Scores range from 18 (total dependence) to 126 (complete independence). FIM scores referenced in this policy refer to the total composite score unless otherwise specified.

Inpatient Rehabilitation Facility (IRF): A free-standing rehabilitation hospital or a distinct part rehabilitation unit of an acute care hospital that provides intensive, hospital-level rehabilitation services for at least three hours per day, five days per week.

Rehabilitation Potential: The clinician-documented expectation that a member will achieve measurable functional improvement within a reasonable timeframe through participation in intensive rehabilitation.

Functional Plateau: A period during which a member demonstrates no measurable improvement in FIM score over seven consecutive days, despite participation in prescribed therapy, in the absence of an acute medical complication. ▲ REVISED

4. COVERAGE CRITERIA

4.1 Admission Criteria

Inpatient rehabilitation is medically necessary for initial admission when ALL of the following criteria are met:

- (A) The member presents with a qualifying diagnosis consistent with a condition expected to benefit from intensive rehabilitation, including but not limited to: stroke, traumatic brain injury, spinal cord injury, hip fracture, major joint replacement, amputation, or neurological disorder with significant functional deficit.
- (B) The member's Functional Independence Measure (FIM) composite score is 60 or higher at the time of admission evaluation, reflecting a level of functional deficit consistent with the need for intensive inpatient rehabilitation.
- (C) The member is medically stable for transfer to an inpatient rehabilitation setting, as documented by the referring physician. "Medically stable" means the member's acute medical condition is sufficiently resolved that active medical management in an acute care hospital is no longer required.
- (D) The member can tolerate and is expected to actively participate in a minimum of three hours of physical, occupational, and/or speech therapy per day, at least five days per week.

- (E) The member's rehabilitation goals are reasonable, measurable, and expected to be achieved within the inpatient setting. Goals must be documented in the rehabilitation plan of care prior to admission.
- (F) Lower levels of care — including skilled nursing facility (SNF), home health, or outpatient therapy — have been considered and determined to be clinically insufficient to meet the member's rehabilitation needs.

4.2 Continued Stay Criteria

Continued inpatient rehabilitation is medically necessary when ALL of the following criteria are met on each concurrent review:

- (A) The member is demonstrating measurable functional progress, defined as a FIM composite score improvement of at least 3 points per week from the admission baseline. Progress must be documented by the treating rehabilitation team in the medical record and available for concurrent review.
- (B) The member is actively and willingly participating in the prescribed rehabilitation program at the required intensity of at least three hours of therapy per day.
- (C) The rehabilitation goals documented in the plan of care remain achievable and clinically appropriate within the inpatient rehabilitation setting.
- (D) There is no clinically appropriate lower level of care available that could safely and effectively meet the member's ongoing rehabilitation needs.
- (E) A qualified rehabilitation physician (physiatrist or attending with rehabilitation privileges) has reviewed the member's progress within the prior 72 hours and documented continued medical oversight as necessary.

4.3 Discharge Criteria

Inpatient rehabilitation is no longer medically necessary, and discharge planning should be initiated, when ANY of the following conditions is present:

- (A) The member has achieved the rehabilitation goals documented in the plan of care, and a safe transition to a lower level of care has been arranged.
- (B) The member has reached a functional plateau as defined in Section 3 — no FIM improvement for seven consecutive days despite active participation in prescribed therapy.
- (C) The member no longer requires or is unable to tolerate the intensity of inpatient rehabilitation (minimum three hours per day), and a clinically appropriate alternative level of care is available.
- (D) The member or member's authorized representative has elected to discharge against medical advice and the decision has been documented.

5. EXCLUSIONS

The following services and circumstances are not covered under this policy:

- Custodial care or maintenance therapy where no measurable functional improvement is expected.
- Inpatient rehabilitation solely for the purpose of caregiver training when the member does not independently meet admission or continued stay criteria.
- Rehabilitation services rendered in a facility not meeting CMS certification standards for an Inpatient Rehabilitation Facility.
- Services that are not documented in an individualized rehabilitation plan of care signed by a qualified rehabilitation physician. ▲ NEW

6. APPLICABLE CODES

This policy applies to claims billed with the following codes. This list is not exhaustive; additional codes may apply based on clinical documentation.

Code Type	Code(s)	Description
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Revenue	0118	Room & Board — Rehabilitation, Private
Revenue	0128	Room & Board — Rehabilitation, Semi-Private
Revenue	0138	Room & Board — Rehabilitation, Ward
Revenue	0148	Room & Board — Rehabilitation, Deluxe
CPT	97530	Therapeutic Activities, each 15 min
CPT	97110	Therapeutic Exercises, each 15 min
CPT	97535	Self-Care/Home Management Training
CPT	92507	Speech/Language/Hearing Treatment
MS-DRG	945, 946, 947	Rehabilitation with/without MCC/CC

7. REFERENCES

- Centers for Medicare & Medicaid Services (CMS). Inpatient Rehabilitation Facility Prospective Payment System.
- Uniform Data System for Medical Rehabilitation (UDSMR). Functional Independence Measure (FIM) Instrument.
- American Academy of Physical Medicine and Rehabilitation (AAPM&R;). Clinical Practice Guidelines.
- Nevada Revised Statutes Chapter 695G — Managed Care.
- Vista Access PPO Evidence of Coverage, applicable plan year.

8. REVISION HISTORY

Version	Effective Date	Approved By	Summary of Changes
v1.0	January 1, 2020	Dr. H. Bergstrom, MD	Initial policy adoption.
v2.0	January 1, 2023	Dr. H. Bergstrom, MD	Revised FIM threshold from 55 to 60 for admission (Criterion B). Added Criterion E (documented functional plateau).
v2.1	January 1, 2025	Dr. H. Bergstrom, MD	Clarified definition of Functional Plateau in Section 3. Added exclusion for services not documented as medically necessary.

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