PAYMENT AND REIMBURSEMENT POLICY

Title: PRP-14 Inpatient Rehabilitation (IPR) Facility Services

Category: Compliance

Effective Date: 08/31/2021

Physicians Health Plan
PHP Insurance Company
PHP Service Company

1.0 Guidelines:

This policy applies to all network and non-network providers, including but not limited to percent of charge contract providers. This policy does not guarantee benefits or solely determine reimbursement. Benefits are determined and/or limited by an individual member's benefit coverage document (COC, SPD, etc.). The Health Plan reserves the right to apply clinical edits to all medical claims through coding software and accuracy of claim submission according to industry billing standards. Clinical edits are derived from nationally recognized billing guidelines such as the Centers for Medicare and Medicaid Services (CMS), National Correct Coding Initiative (NCCI), the American Medical Association (AMA), and specialty societies. The Health Plan may leverage the clinical rationale of CMS or other nationally sourced edits and apply this rationale to services that are not paid through CMS but which are covered by the Health Plan to support covered benefits available through one of the Health Plan's products. Prior approval does not exempt adherence to the following billing requirements. The provider contract terms take precedence if there is a conflict between this policy and the provider contract.

2.0 Description:

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

For patients with neurological diagnoses, a neuropsychologist is on staff to determine if they need additional psychological or psychiatric treatment. In an acute rehabilitation program, the patient is expected to make significant functional gains and medical improvement within a reasonable time frame. A patient must be able to tolerate an intensive level of rehabilitation services consisting of a minimum of three hours of therapy per day, up to six days a week. Therapy is provided on both a one-to-one and group basis, depending on the needs of the individual. Additional services are also available, such as respiratory therapy, social worker assistance, and therapeutic recreation programs.

3.0 Policy:

This policy applies to facility claims. Health Plan reimburses inpatient rehabilitation services provided by an inpatient rehabilitation facility (IRF) within the member's applicable benefit limit. Reimbursement is calculated based on specific contracted payment rates (i.e., Per Diem Rate).

The Health Plan reimburses for the following IRF services:

- Facility charges.
- Medical supplies and other non-Physician services received during the inpatient stay.
- Skilled care as defined by the benefit plan.

The Health Plan does not provide reimbursement for:

- Custodial care.

- Care for senility or developmental disability.

4.0 Coding and Billing:

Bill IPR Professional services as defined by provider contract via CMS-1500.

COVERED CODES	
CODE	DESCRIPTION
99221	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit. Initial hospital care, per day, for E&M of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive exam; and Medical decision making that is straightforward or of low complexity.
99222	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.
99223	Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.
99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.
99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is

	responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.
99234	Observation or inpatient hospital care, for E&M of a patient including admission and discharge on the same date, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive exam; and Medical decision making that is straightforward or low complexity
99235	Observation or inpatient hospital care, for E&M of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity
99236	Observation or inpatient hospital care, for E&M of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity
99238	Hospital discharge day management; 30 minutes or less
99239	Hospital discharge day management; more than 30 minutes

Bill IPR services as defined by provider contract via UB-04.

Revenue Codes

- 0118 Room and board, private; rehabilitation.
- 0128 Room and board, semi-private; rehabilitation.
- 0138 Room and board, semi-private; rehabilitation.
- 0148 Room and board, private, deluxe; rehabilitation.
- 0158 Room and board, ward, rehabilitation.

Leave of Absence (LOA) or Furlough Days

Leave of absence (LOA) or furlough days are “time away” dates during which a patient is discharged from but remains a patient of an inpatient hospital, residential treatment program, or skilled nursing facility. If the patient has progressed to the point of being able to be away from the facility, or is expected for follow-up care or surgery and the patient does not require a hospital level of care during the interim period, an LOA or furlough may be granted.

There is no reimbursement for LOA or furlough days as services are not being provided to the patient.

The Leave of Absence accommodation revenue codes 018X are billed to indicate the days that the patient was not in the facility. These codes indicate routine service charges including zero charges for holding a room while the patient is temporarily away from the provider. Use of this revenue code also requires that occurrence span code 74-Noncovered level of care/LOA, and date(s) of the absence.

Leave of Absence 018X revenue codes:

- 0180 – Leave of Absence—General.
- 0182 – Leave of Absence—Patient Convenience.
- 0183 – Leave of Absence—Therapeutic Leave.
- 0185 – Leave of Absence—Nursing Home (for Hospitalization).
- 0189 – Leave of Absence—Other LOA.

Discharges/Transfers

Discharge status codes are required for hospital inpatient claims including IRFs. A patient discharge status code is defined as a two-digit code that identifies where the patient is being discharged to at the end of their facility stay, or where they will be transferred to such as an acute/post-acute facility. The discharging facility should ensure that documentation supports the billed discharge status code. Failure to submit the appropriate code can result in denial of claims, delayed payments, or even return of reimbursement.

Condition Codes (Fields 18-28)

Required if applicable. Situational two-digit codes that are entered in numerical order to describe any of the pertinent conditions or events that apply to the billing period of the claim.

Occurrence Codes (Fields 31-34)

Required if applicable. Codes and dates defining specific event(s) related to the billing period of the claim. Event codes are two-digits and dates are six numeric digits (MMDDYY).

Occurrence Span Code and Dates (Field 35-36)

Required for inpatient claims. The provider must enter codes and associated beginning and ending dates defining a specific event relating to the billing period of the claim. Event codes are two-digits and dates are six numeric digits (MMDDYY).

Value Codes and Amounts (Fields 39-41)

- Required if applicable. Codes and related dollar amount(s) identifying data of a monetary nature that are necessary for the processing of claims. The codes are two-digits, and each value allows up to nine numeric digits (0000000.00). Negative amounts are not allowed except in Field 41. Whole numbers or non-dollar amounts are right justified to the left of the dollars and cents delimiter. Some values are reported as cents, so the provider must refer to specific codes for instructions.
- If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are four lines of data, line “a” through line “d.” The provider uses FLs 39A through 41A before 39B through 41B (i.e., it uses the first line before the second).

Out of network and CMS based contracted providers must bill in accordance with CMS regulations

- Health Insurance Prospective Payment System Codes(HIPPS) required.
  - IRF utilize information from a patient assessment instrument (IRF PAI) to classify patients into distinct groups based on clinical characteristics and expected resource needs. Separate payments are calculated for each group, including the application of case and facility level adjustments.
- HIPPS codes must be billed with Revenue Code 0024 with 1 unit.
- Revenue code 0024 should be reported with $0 charges.
- Outliers- An IRF is eligible for an outlier payment if the IRF's costs exceed the outlier threshold for that discharge.

5.0 Documentation Requirements:

The following should be supported in the medical record:

- Preadmission screenings, assessments and evaluations.
- Interdisciplinary communications.
- Patient's need for intensive, multi-disciplinary rehabilitation, that require the need for an inpatient setting, including need for safety to achieve medically desires results.
- The therapy is being provided in a specially designated area of an acute care hospital or facility.
- Physical, occupational, and speech therapy time per day.
- Legible physician and/or clinician signatures.
- Dated Physician or Non-Physician Practitioner (NPP) order(s).
- All related care plan notes, history, progress reports, treatment encounters, lab results, therapy minute logs and discharge summary.
- Itemization of revenue codes.

6.0 Verification of Compliance:

Claims are subject to audit, prepayment and post payment, to validate compliance with the terms and conditions of this policy.

7.0 Terms & Definitions:

Health Insurance Prospective Payment System (HIPPS) -- Represent specific sets of patient characteristics (or case-mix groups) health insurers use to make payment determinations under several prospective payment systems.

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

Leave of Absence (LOA) or Furlough Days - Leave of absence (LOA) or furlough days are “time away” dates during which a patient is discharged from but remains a patient of an inpatient hospital, residential treatment program, or SNF.

Per Diem Payment - The payment made to Provider for each day of an Admission of a Member as authorized by Payor. Such payment shall be considered payment in full for all Health Services rendered to the Member during each day of the Admission including, but not limited to, nursing care, diagnostic and therapeutic services, routine radiology, routine laboratory, routine supplies, over the counter medications, and room and board charges rendered, unless otherwise provided for in the Provider Agreement. Other exclusions may apply, please refer to Provider Agreement for additional details.

8.0 References, Citations & Resources:

Centers for Medicare and Medicaid Services, CMS Manual and other CMS publications.

American Medical Association (AMA), Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) and associated publications.

Michigan Scope of Practice Policy

Michigan Legislature Public Health Code Act 368 of 1978 Section 333.16215 & Section 333.17047

Uniformed Billing Editor.

Associated Benefit Coverage Policy: BCP-23 Inpatient Rehabilitation (IPR) Services

9.0 Revision History:

Original Effective Date: 01/01/2020

Next Revision Date: 10/01/2022

Revision Date	**Reason for Revision**
11/20	Annual review, no changes, approved by CCSC 11/06/2020
6/21	Annual review; table of procedure codes added, updated Guidelines verbiage