Inpatient Rehabilitation Facility (Acute Rehabilitation): Neurological Disorders

MCG Health
Recovery Facility Care
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Link to Codes

Clinical Indications for Admission to Inpatient Rehabilitation Facility (Acute Rehabilitation)

- **Inpatient rehabilitation facility** (acute rehabilitation) admission may be indicated by **ALL** of the following(1)(2)(3):NNNN
  - No acute hospital care needs

- Preadmission screening completed; assessment examples include[A][B](1):
  - Level of function prior to the event
  - Condition that caused the need for rehabilitation
  - Expected level of improvement
  - Expected length of time to achieve level of improvement
  - Risk for clinical complications
  - Combination of treatments needed (PT, OT, SLP, or orthosis/prosthesis)
  - Anticipated discharge destination
- Patient status supports **active** participation in, and benefit from, intensive rehabilitation Skilled care that includes **ALL** of the following[C](2)(16):
  - Intensity and complexity of nursing, medical management, and rehabilitation needs required and can be expected to benefit from an inpatient stay and interdisciplinary team approach.
  - Ability to actively participate in Intensive rehabilitation therapy program
  - Patient can reasonably be expected to demonstrate Goals for measurable improvement.
  - Requires physician supervision to assess the patient both medically and functionally[D]
  - Requires an intensive and coordinated Interdisciplinary team care approach[E]
- Therapy services needed, including **ALL** of the following(29)(30):
  - Skilled therapy services needed for **1 or more** of the following(33)(34):
    - Augmentative and alternative communication device training(35)
    - Edema-management techniques
    - Environmental and activity modification for ADL performance(35)(36)
    - Equipment and adaptive technology use and safety
    - Fall-prevention and recovery training(37)
    - Functional activities evaluation and training
    - Gait evaluation and training(38)
    - Motor control and balance evaluation and training(39)
    - Neurobehavioral and neurocognitive assessment and treatment strategies (eg, learning, memory, attention, problem-solving, abstract reasoning, and impulsivity)(40)
    - Orthosis or prosthesis evaluation and training(41)(42)
    - Pain-management techniques(43)(44)
    - Positioning techniques and training
    - Range of motion evaluation and training(35)
    - Restoration of speech or swallowing with services of speech-language pathologist (SLP)(45)
    - Safety awareness training related to functional mobility and ADL performance(40)
    - Strength evaluation and training(46)(47)(48)
    - Therapeutic exercises or activities supervision to ensure patient safety and treatment effectiveness(44)(46)(47)(48)
  - Multidisciplinary therapy services needed, including **2 or more** of the following(49)(50)(51):
    - Physical therapy (PT)
    - Occupational therapy (OT)
    - Other therapy, including **1 or more** of the following:
      - Speech-language pathology (SLP) therapy
      - Orthosis or prosthesis
- Nursing services needed, including **1 or more** of the following(16)(52):

- Behavioral health condition monitoring(40)(42)
- Bowel and bladder management(53)(54)
- Coordination of care between interdisciplinary team members
- Infusion therapy management
- Medical condition monitoring with evaluation of rehabilitation on clinical status
- Musculoskeletal management(35)(55)
- Nutritional management(42)(56)
- Respiratory management(42)
- Therapy skills incorporated and reinforced in nursing care
- Time-tabling and routine establishment (eg, for ADL adaptation)(35)
- Pain management(43)
- Patient and caregiver education (eg, safety, skin care, medication)(35)
- Wound management

Alternative Levels of Care

- Patient may be candidate for other levels of care, including:
  - Subacute or skilled care. See:
    - Encephalopathy RFC
    - Meningitis RFC
    - Multiple Sclerosis RFC
    - Parkinson Disease RFC
    - Seizure RFC
  - Home care. For admission criteria, see:
    - Amyotrophic Lateral Sclerosis HC
    - Meningitis HC
    - Multiple Sclerosis HC
    - Muscular Dystrophy HC
    - Parkinson Disease HC
    - Seizure HC

Length of Stay

Length of stay is displayed as percentiles that are based on the observed utilization of inpatient rehabilitation facility length of stay for this diagnosis. For guidelines with low claims data volume, length of stay statistics that are displayed are from combined categories (eg, major postoperative and major medical). Individual patients may require shorter or longer stays as appropriate for their clinical status and care needs. This table is designed to allow organizations to define their goals for inpatient rehabilitation utilization by choosing from the displayed range.

Inpatient Rehabilitation Facility Commercial Length of Stay	Inpatient Rehabilitation Facility Medicare Length of Stay

10%ile	20%ile	30%ile	40%ile	50%ile	10%ile	20%ile	30%ile	40%ile	50%ile
6	8	9	11	12	7	9	10	11	12

Evaluation and Treatment

General Treatment Course

Stage	Clinical Status	Interventions
1	• **Clinical indications for admission met** • Inpatient Rehabilitation Admission Assessment complete with intensive rehabilitation needs and services identified and evaluation of current level of functioning (eg, Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI))[F][G] • Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) Assessment SR complete for evaluation of current level of functioning (eg, Activities of Daily Living (ADL) Scoring Tool Calculator) **QM** • Physical ability assessment (eg, FIM Score®, Functional Independence Measure for children (WeeFIM®)) • Pressure injury assessment (ie, risk for new or presence of existing pressure injury). See Wounds Due to Surgery, Injury, or Pressure SR for further information. **QM** • Psychosocial status assessment. See Psychosocial Assessment SR for further information. **QM** • Social determinants of health screening. See Social Determinants of Health Screening Tool SR for further information. **QM**(60) • Hospital readmission risk factor evaluation **QM** (61)(62)	• Transition of care planning initiated with evaluation for next level of care **QM** (63) • Interdisciplinary care plan established and implemented **QM** [H](2)(64) − Provide treatments and monitoring: ◦ Behavioral management(65) ◦ Bladder management(66) ◦ Bowel management(66) ◦ Chronic condition management as indicated ◦ Cognitive management techniques(67)(68) ◦ Fall risk management **QM** (69) ◦ Fluid and electrolyte management(70) ◦ Infusion (IV or subcutaneous) therapy management (eg, fluids, antibiotics, parenteral nutrition)(71)(72) ◦ Laboratory testing or monitoring, if ordered(70) ◦ Medication management **QM** (73) ◦ Nutrition management(56)(66) ◦ Pain management(74)(75) ◦ Pressure injury management **QM** (76) ◦ Respiratory care(35) ◦ Thromboprophylaxis ◦ Tracheostomy management(75) ◦ Wound or dressing management • Education for self-care • Physical therapy (PT) evaluation • Occupational therapy (OT) evaluation • Speech-language pathology (SLP) evaluation

		• Neuropsychological (eg, neurocognitive and neurobehavioral) evaluation, if indicated(12)(40) • Orthosis or prosthesis evaluation, if indicated(30) • Social work or case management evaluation(1)(2)(77)
2	• **Intensive rehabilitation therapy program established and patient actively participating[I]** • Unexpected clinical event resolved (eg, infection, DVT, pneumonia)[J](2) • Patient demonstrating measurable practical improvement in functional condition with evaluation of current level of functioning (eg, Activities of Daily Living (ADL) Scoring Tool Calculator) **QM**(78) • **Physical therapy (PT) progression** • **Occupational therapy (OT) progression** • **Speech-language pathology (SLP) progression** • **Other care needs stable or diminished**	• Interdisciplinary care plan continues **QM** • Ongoing assessment of clinical needs **QM** − Provide treatments and monitoring: ◦ Behavioral management ◦ Bladder management ◦ Bowel management ◦ Chronic condition management as indicated ◦ Cognitive management techniques ◦ Fall risk management **QM** ◦ Fluid and electrolyte management ◦ Infusion (IV or subcutaneous) therapy management (eg, fluids, antibiotics, parenteral nutrition)(71) ◦ Laboratory testing or monitoring, if ordered ◦ Medication management **QM** (73) ◦ Nutrition management ◦ Pain management ◦ Pressure injury management **QM** ◦ Respiratory care ◦ Thromboprophylaxis ◦ Tracheostomy management ◦ Wound or dressing management • Ongoing patient or caregiver education • Ongoing equipment (eg, DME) training • Ongoing rehabilitation therapy(2) • Ongoing neuropsychological management, if indicated • Orthosis or prosthesis training, if indicated • Transition of care planning continues with evaluation for next level of care **QM** (79)

3	• **Adequate intensive inpatient rehabilitation completed for safe transfer to next level of care, or patient's condition prevents active participation in intensive therapy program, or patient no longer demonstrating significant functional gains (eg,**  **Activities of Daily Living (ADL) Scoring Tool Calculator)** • **Bowel and bladder management training completed** • **Communication technique training completed** • **Equipment (eg, DME) training completed** • **Gastrointestinal status stable or manageable at lower level of care** • **Genitourinary status stable or manageable at lower level of care** • **Medical status stable or manageable at lower level of care (eg, vital signs, laboratory values)** • **Neurobehavioral and neurocognitive status manageable at lower level of care** • **Neurovascular status stable or manageable at lower level of care** • **Orthosis or prosthesis training completed or manageable at lower level of care** • **Pain controlled or manageable at lower level of care** • Patient and caregiver education completed or manageable at lower level of care • Patient transitioned to another level of care due to unexpected clinical event (eg, DVT, infection) • **Respiratory status stable or manageable at lower level of care** • **Wound(s) or dressing changes manageable at lower level of care** • **Transition plans and education understood**	• **Transition of care planning completed QM** • Safe to go home and transition to community or transition to alternative level of care (eg, skilled nursing facility, home care) **QM**

N

Recovery Milestones are indicated in **bold**.

Extended Stay

Extended recovery facility stay may be: brief (1 to 3 days), moderate (4 to 7 days), or prolonged (more than 7 days).

- Extended stay beyond goal length of stay may be indicated when **ALL** of the following exist:
  - No acute hospital care needs
  - Patient able to make measurable improvement in functional condition in predetermined and reasonable period of time
  - Intensity of medical and rehabilitation management necessitates inpatient stay.
  - Coordinated interdisciplinary team approach required to manage intensity of medical and rehabilitation needs
  - Therapy services required, including **2 or more** of the following:
    - Physical therapy (PT)
    - Occupational therapy (OT)
    - Other therapy, including **1 or more** of the following:
      - Speech-language pathology (SLP) therapy
      - Orthosis or prosthesis
  - Patient has had an unexpected clinical event and Skilled care needed on daily basis for **1 or more** of the following[J](2):

- Deep venous thrombosis (DVT) or pulmonary embolus (PE) management; examples include(82):
  - Pharmacoprophylaxis initiation(83)
  - Hemodynamic measurements outside normal limits
  - Laboratory values outside normal limits.
  - Signs of active bleeding
  - Expect brief stay extension.
- Fall management; examples include(84)(85):
  - Functional status impaired, impacting ability to actively participate in intensive rehabilitation program
  - Evaluation and treatment of fall injury, injury regimen established within 3 days of fall, and intensive rehabilitation program resumed(2)
  - Expect brief stay extension.
- Fever management; examples include(86):
  - Temperature status outside prescribed limits
  - Laboratory values outside normal limits(87)
  - Hemodynamic measurements outside normal limits
  - Behavioral symptoms (eg, agitation, somnolence, or inappropriate behavior) that interfere with medical care
  - Expect brief stay extension.
- Infusion therapy; examples include(2)(71):
  - Administration of agent (eg, chemotherapy, new intravenous medication) that requires clinical management and may require brief break in intensive therapy rehabilitation program(88)
  - Expect brief stay extension.
- Malnutrition, dehydration, or electrolyte management; examples include:
  - Oral nutrition and hydration not tolerated and enteral or parenteral nutrition implemented
  - Enteral or parenteral nutrition complications present(89)
  - Transition from enteral or parenteral nutrition to oral nutrition(90)
  - Hemodynamic measurements outside normal limits
  - Laboratory values outside normal limits(91)
  - Urinary output below prescribed parameters(91)
  - Expect brief stay extension.
- Mental status changes; examples include(92):
  - Danger to self or others
  - Behavior crisis management (eg, physical or chemical restraints) needed(93)
  - Behavioral symptoms (eg, agitation, somnolence, or inappropriate behavior) that interfere with medical care
  - Sudden disturbances in consciousness, changes in cognition (eg, disorientation, memory loss, or language impairment), or disturbances in thought that prevent intensive therapy services
  - Laboratory values outside normal limits
  - Expect brief stay extension.
- Pain evaluation and management; examples include(94)(95)(96):
  - Frequent pain assessment using validated diagnostic tool[K]
  - Early referral and treatment of pain
  - Ongoing education and training of pain treatment plan (eg, multimodal pain management)[L][M]
  - Pain medication side effects or risk factors for adverse effects (eg, constipation, sedation, falls)
  - Expect brief to moderate stay extension.

- Significant comorbid disease exacerbation with need for skilled clinical intervention and monitoring; examples include(2)(98):
  - Hyperglycemia or hypoglycemia
  - Hypertension or hypotension
  - Inadequate pain management
  - Condition assessment or care unmanageable at lower level of care
  - Expect brief extension stay.
- Urinary management; examples include(99)(100):
  - Urinary catheter or percutaneous suprapubic tube complications
  - Urinary output inadequate for medical condition(101)
  - Laboratory values outside normal limits(70)(102)
  - Expect brief stay extension.
- Wound management; examples include(103):
  - Wound status changed with new type of dressing or procedure
  - New wound developed (eg, pressure injury)
  - Healing impeded due to comorbidities (eg, diabetes, malignancy)
  - Nutrition or hydration inadequate for normal duration of healing
  - Expect brief stay extension.

Rehabilitation Treatment Plan

Physical Therapy Treatment Plan

- **Physical therapy** treatment plan includes(104):
  - Goals of physical therapy(39)(66)(105)(106)(107)(108)
    - Activity tolerance and functional endurance improved
    - ADL/IADL performance, independence, and safety optimized
    - ADL/IADL restrictions, precautions, or activity guidelines understood
    - Awareness of community resources optimized
    - Chronic condition modifiable risk factor management strategies maximized(109)
    - Durable medical equipment usage optimized
    - Energy conservation techniques and proper body mechanics maximized
    - Exercise tolerance and functional endurance improved
    - Fall-risk-reduction strategies maximized
    - Functional independence and safety with mobility-related tasks maximized
    - Home rehabilitation program and recommendations understood
    - Orthosis or prosthesis management and independence maximized(110)(111)(112)
    - Pain-management techniques optimized
    - Potential personality or emotional changes understood
    - Pressure injury and contracture risk prevention maximized
    - Respiratory status and breathing techniques improved
    - Risk and disability associated with disease, injury, or surgical procedure understood
    - Self-management of health, injury, surgical procedure, or disease process optimized
    - Self-reported quality of life improved
    - Strength and range of motion improved

- Postdischarge complication risk factors minimized

− Rehabilitation techniques and training(39)(66)(106)(107)(108)

- Abnormal tone or spasticity management(50)(113)
- ADL training
- Age-appropriate functional strategies and techniques in alignment with developmental progression(114)(115)
- Constraint-induced movement therapy and/or modified constraint-induced movement therapy(116)
- Contracture prevention or management(117)
- Edema prevention or management(118)
- Education of therapeutic program with patient and caregiver
- Energy conservation and work simplification(119)
- Equipment and device use training(120)
- Exercise program setup and progression within precautions, which may include(29)(121)(122):
    - Aerobic exercises or endurance conditioning(123)
    - Balance training(124)
    - Coordination exercises
    - Range-of-motion techniques
    - Respiratory exercises and training (eg, respiratory muscle training, coughing techniques, deep breathing exercises, incentive spirometry exercises, pursed lip and diaphragmatic breathing)(125)(126)
    - Strengthening exercises(109)
    - Stretching exercises
- Fall-prevention and recovery training **QM** (127)(128)(129)
- Functional skills training with applicable durable medical equipment (eg, walker, transfer board)(130)
    - Bed mobility training
    - Body weight-supported gait training (eg, robot-assisted gait training)(131)
    - Gait training on level and uneven surfaces
    - Stair management
    - Transfer training
    - Wheelchair mobility and management(132)(133)(134)
- Lifting as prescribed for diagnosis (eg, medical, surgical)
- Manual therapy (eg, soft tissue mobilization techniques, scar management, massage)(135)
- Neuromuscular re-education (eg, proprioception training)(136)
- Pain-management strategies and techniques(137)
- Posture, positioning, and body mechanics as prescribed for diagnosis or surgical approach
- Pressure injury prevention or management(138)
- Safety awareness education
- Self-management of health, injury, surgical procedure, or disease process(139)(140)
- Sensory stimulation and integration techniques(124)(141)
- Splint, brace, cast, prosthesis, or orthosis management(110)(111)(112)(142)
- Therapeutic physical modality use and training, as indicated(143)
    - Cold modalities or cryotherapy with precautions related to circulatory deficiency, areas of desensitization, open wounds, or fractures
    - Functional or neuromuscular electrical stimulation
    - Thermal modality with precautions related to circulatory deficiency, areas of desensitization, open wounds, or fractures
    - Transcutaneous electrical nerve stimulation (TENS)

- Vestibular rehabilitation or vertigo management(46)(48)(144)

- Discharge recommendations, which may include:
  - Activity modifications
  - Environmental adaptation
  - Home exercise program as prescribed
  - Home modifications

Occupational Therapy Treatment Plan

- **Occupational therapy** treatment plan includes(145)(146)(147):
  - Goals of occupational therapy(34)(148)(149)
    - Activity tolerance and functional endurance improved
    - ADL/IADL performance, independence, and safety optimized
    - ADL/IADL restrictions, precautions, or activity guidelines understood
    - Balance and body alignment for ADL/IADL improved
    - Cognitive skills for ADL/IADL improved
    - Fall-risk-reduction strategies maximized
    - Home rehabilitation program and recommendations understood
    - Pain-management techniques optimized
    - Participation arousal within environment improved
    - Potential personality or emotional changes understood
    - Proper posture for sitting, ADL, and transfers maximized
    - Upper body range of motion, strength, and functional use for ADL or IADL maximized
    - Upper extremity joint range of motion for functional tasks maximized
    - Upper extremity motor control improved
    - Visual and visual perception function for safe participation in functional tasks optimized
    - Postdischarge complication risk factors minimized
  - Rehabilitation techniques and training(34)(148)
    - Abnormal tone or spasticity management
    - ADL or IADL training
    - Age-appropriate functional strategies and techniques in alignment with developmental progression
    - Behavior-management strategies and techniques (eg, cognitive behavioral therapy, cognitive rehabilitation techniques)(150)
    - Compensatory strategies for completion of ADL/IADL
      - Cognition impairment management(131)
      - Energy conservation(151)
      - One-handed techniques
      - Perceptual deficits management
      - Sensory impairment management
      - Visual impairment management
      - Work simplification
    - Contracture prevention or management(117)
    - Edema prevention or management(152)
    - Education of therapeutic program with patient and caregiver

- Environmental and activity modification for ADL/IADL performance
- Equipment and device use training
- Exercise program setup and progression within precautions, which may include:
  - Balance training
  - Coordination exercises
  - Range-of-motion techniques
  - Strengthening exercises
  - Stretching exercises
- Fall-prevention and recovery training **QM** (127)
- Functional skills training with applicable durable medical equipment (eg, shower chair, commode)(153)
  - Bed mobility training
  - Transfer training
  - Wheelchair mobility and management(132)
- Joint-protection techniques and mobilization
- Manual therapy (eg, soft tissue mobilization techniques, scar management, massage)(135)
- Neuromuscular re-education (eg, proprioception training)(154)
- Pain-management strategies and techniques
- Posture, positioning, and body mechanics as prescribed for diagnosis or surgical approach
- Safety awareness education
- Sensory stimulation and integration techniques
- Splint, brace, cast, prosthesis, or orthosis management
- Stress-management techniques(155)

Discharge recommendations, which may include(156):

- Activity modifications
- Environmental adaptation
- Home exercise program
- Home modifications
- Pre-driver assessment and automobile modification
- Vocational rehabilitation(155)

Speech-Language Pathology Treatment Plan

- **Speech-language pathology** treatment plan includes(157):

Aphasia management(158)(159)(160)

- Goals of speech-language pathology therapy
  - Auditory comprehension for simple to complex language (eg, yes/no questions to open-ended questions) improved
  - Compensatory communication techniques to include use of gestures and environmental controls improved
  - Linguistic memory without delay improved for word recall, sentences, and lists
  - Word-finding improved
  - Written language comprehension, expression, and use improved
- Rehabilitation techniques and training(161)
  - Compensatory communication training
  - Computer-based communication training program
  - Education of therapeutic program with patient and caregiver

- Expressive language facilitation techniques
- Receptive language facilitation techniques

- Apraxia of speech management(160)(162)(163)
  - Goals of speech-language pathology therapy
    - Compensatory communication techniques to include use of gestures and environmental controls improved
    - Motor speech accuracy for speech sound production improved
    - Rhythm, rate, and intonation of connected speech improved
    - Speech intelligibility and clarity in connected/conversational speech improved
  - Rehabilitation techniques and training(161)
    - Compensatory communication training
    - Education of therapeutic program with patient and caregiver
    - Repetitive articulation exercises for improved motor speech accuracy
    - Speech production activities targeting initiation, fluency, and effort level of speech
- Augmentative and alternative communication (AAC) management(160)(163)(164)(165)(166)
  - Goals of speech-language pathology therapy
    - AAC supports or devices used
    - Compensatory communication techniques to include use of gestures and environmental controls improved
  - Rehabilitation techniques and training(161)
    - Compensatory communication training
    - Education of therapeutic program with patient and caregiver
    - High-technology communication device use (eg, speech synthesizers, computer-based systems, FM systems)(167)
    - Low-technology communication device use (eg, picture boards, word boards, alphabet boards, dry erase boards)
  - Equipment, supplies, or supportive device training; examples include:
    - AAC device (eg, word or picture boards, computer-based system)
- Cognitive-communicative deficit management(160)(168)
  - Goals of speech-language pathology therapy
    - Attention and awareness improved
    - Cognitive-communication function improved
    - Compensatory communication techniques to include use of gestures and environmental controls improved
    - Memory, organization, initiation, reasoning, problem-solving, and executive function improved
    - Social language skills improved
  - Rehabilitation techniques and training(161)
    - Attention training (eg, sustained attention, focused attention, divided attention)
    - Communication effectiveness training
    - Compensatory communication training
    - Education of therapeutic program with patient and caregiver
    - Immediate, short-term, and long-term memory training
    - Organization, initiation, reasoning, problem-solving, and executive function training
    - Orientation training (eg, person, place, time, event, situation)
    - Pragmatic/social language training (eg, eye contact, turn taking, topic maintenance, affect, body language)
    - Verbal integration training (eg, understand and use abstract language, cause-effect, if-then situations, and compare-contrast ideas)
  - Equipment, supplies, or supportive device training; examples include(169):

- Memory and organization support systems for daily use (eg, computer or smartphone for calendar, planner, and reminders; signs within home; use of calendar or datebook; direct access to emergency phone numbers)

- Dysarthria management(160)(163)(170)
  - Goals of speech-language pathology therapy
    - Compensatory communication techniques to include use of gestures and environmental controls improved
    - Motor speech accuracy for speech sound production improved
    - Voice quality, pitch, loudness, resonance, or prosody (rhythm and cadence) improved
    - Speech intelligibility and clarity in connected/conversational speech improved
  - Rehabilitation techniques and training(161)
    - Compensatory communication training
    - Education of therapeutic program with patient and caregiver
    - Modification and training of rhythm, rate, and intonation of speech
    - Motor speech accuracy training targeting distortions, substitutions, omissions, and other errors
    - Oral motor exercises for increased strength, accuracy, and speed of articulation
    - Relaxation exercises and stretching to reduce spasticity or rigidity of musculature
    - Respiratory support training for speech production
  - Equipment, supplies, or supportive device training; examples include(169):
    - Memory and organization support systems for daily use (eg, computer or smartphone for calendar, planner, and reminders; signs within home; use of calendar or datebook; direct access to emergency phone numbers)
    - Oral prosthesis fitting use and care(171)(172)
- Dysphagia management[N](160)(163)(169)(174)(175)
  - Goals of speech-language pathology therapy
    - Diet advanced from nonoral to oral intake
    - Education and training on dietary modifications and restrictions provided
    - Education on aspiration signs, symptoms, and prevention provided
    - Effective swallowing strategies, techniques, or maneuvers safely used
    - Oral, pharyngeal, and laryngeal coordination for airway protection during swallowing improved(176)
    - Oral, pharyngeal, and laryngeal motor strength, range of motion, and endurance for secretion and bolus management improved(176)
    - Recommended diet and liquids safely tolerated, reducing or eliminating risk of aspiration
    - Respiratory support and glottal closure for swallowing improved
  - Rehabilitation techniques and training(172)(173)
    - Airway protection techniques
    - Aspiration pneumonia or recurrent pneumonia management and prevention
    - Aspiration precaution training
    - Bolus management and control training
    - Compensatory swallowing maneuver training, as indicated
    - Compensatory swallowing strategy training
    - Education of therapeutic program with patient and caregiver
    - Neuromuscular electrical stimulation
    - Optimal diet consistency identification and preparation training to minimize risk of choking and aspiration(177)(178)
    - Oral pharyngeal exercises
    - Saliva management and control techniques

- Sensory stimulation
- Trial oral feedings for diet advancement(178)

- Equipment, supplies, or supportive device training; examples include(169)(179)(180):
  - Adaptive feeding equipment use (eg, different size or shaped spoon, nose cut-out cup)
  - Liquid thickeners
  - Positioning devices during oral intake (eg, chair, wedges, pillows)
  - Removable dentures, obturators, or other oral device/appliance management(171)(172)

- Voice disorder management[O](160)(162)(164)(181)(182)
  - Goals of speech-language pathology therapy
    - Compensatory communication techniques to include use of gestures and environmental controls improved
    - Respiration and speech coordination improved
    - Ventilator-assisted or tracheostomy vocalization techniques used(183)(184)
    - Voice quality, pitch, loudness, resonance, or prosody (rhythm and cadence) improved
  - Rehabilitation techniques and training(161)
    - Compensatory communication and optimal voice usage training (eg, phone calls, interaction with caregivers, communication when there is background noise)
    - Education of therapeutic program with patient and caregiver
    - Oral, pharyngeal, and laryngeal exercises
    - Respiratory support training
    - Use of ventilator-assisted or tracheostomy vocalization techniques(183)(184)
    - Vocal behavior modification (eg, intensity, pitch, resonance, rate)
  - Equipment, supplies, or supportive device training; examples include:
    - Digitized or synthesized speech(166)
    - Speaking valve or cap for tracheostomy or ventilator(183)(184)
    - Voice amplification device(167)

- Discharge recommendations, which may include(185):
  - Activity modifications(166)
  - Environmental adaptation
  - Home exercise program
  - Home modifications

Patient Education

- Patient and caregiver education. See:
  - Amyotrophic Lateral Sclerosis: Patient Education for Clinicians SR
  - Encephalopathy: Patient Education for Clinicians SR
  - Meningitis, Bacterial: Patient Education for Clinicians SR
  - Meningitis, Suspected or Viral: Patient Education for Clinicians SR
  - Multiple Sclerosis: Patient Education for Clinicians SR
  - Muscular Dystrophy: Patient Education for Clinicians SR
  - Parkinson Disease: Patient Education for Clinicians SR

- Seizure: Patient Education for Clinicians SR

Discharge Planning

- Transition of care planning may include(30): NN
  - Assessment and early establishment of anticipated discharge destination and plans for care, including(195):
    - Treatment plan development involving multiple providers
    - Premorbid functioning
    - Patient and caregiver preferences and abilities
    - Evaluation for skilled services at next level of care as appropriate for patient's continued needs
    - Psychosocial status. See Psychosocial Assessment SR for further information. **QM**(196)
    - Social determinants of health screening. See Social Determinants of Health Screening Tool SR for further information. **QM**(60)
    - Acceptance for care for patient at next level of care, as appropriate
  - Transition of care plan complete, which may include:
    - Patient and caregiver education complete. See Teach-Back Tool SR for further information.
    - Medication reconciliation completion includes **QM** (197)(198):
      - Compare patient's discharge list of medications (prescribed and over-the-counter) against provider's admission or transfer orders.
      - Assess each medication for correlation to disease state or medical condition.
      - Report medication discrepancies to prescribing provider, attending physician, and primary care provider, and ensure accurate medication order is identified.
      - Provide reconciled medication list to all treating providers.
      - Confirm that patient or caregiver can acquire medication.
      - Educate patient and caregiver.
        - Provide complete medication list to patient and caregiver.
        - Importance of presenting personal medication list to all providers at each care transition, including all provider appointments
        - Reason, dosage, and timing of medication (eg, use "teach-back" techniques)(199)(200)
      - Encourage communication between patient, caregiver, and pharmacy for obtaining prescriptions, setting up home medication delivery, and reviewing for drug-drug interactions.
      - See Medication Reconciliation Tool SR for further information.
    - Appointments planned or scheduled(79):
      - Primary care provider
      - Behavioral health provider(48)(65)(201)
      - Neurologist(202)(203)
      - Neuropsychologist(33)
      - Ophthalmologist(202)
      - Outpatient imaging, tests, or procedures(33)
      - Palliative or end-of-life care provider(47)(204)
      - Physiatrist or rehabilitation provider
      - Prostheses or orthoses provider
      - Rehabilitation therapy (eg, PT) at next level of care(65)(79)(205)
      - Respiratory therapy

- Specialists for management of comorbidities as needed(33)
- Surgeon(206)
- Other

- Referrals made for assistance or support, which may include:
  - Behavioral health support (eg, counseling)
  - Community services(207)(208)
  - Educational program (eg, chronic condition management, self-management)(199)
  - End-stage disease planning
  - Financial, for follow-up care, medication, and transportation
  - Home architectural modifications(209)(210)(211)
  - Home healthcare(212)(213)
  - Local electric or power company regarding need for life support if ventilator needed at home
  - Protective services or legal authorities, if indicated(214)(215)
  - Self-help or support groups(65)(216)
  - Social services (eg, social programs, advance directives)(65)
  - Tobacco use treatment, as needed **QM** (217)(218)
  - Vocational rehabilitation(155)(213)
  - Other
- Medical equipment and supplies coordinated (ie, delivered or delivery confirmed), as indicated(219):
  - ADL-supportive equipment
  - Bowel care equipment and supplies
  - Cardiac care equipment and supplies (eg, compression stockings)(82)
  - Medication equipment and supplies
  - Nutritional care equipment and supplies
  - Orthopedic equipment
  - Respiratory equipment and supplies
  - Urinary care equipment and supplies
  - Wound care equipment and supplies
  - Other
- Transition plan communicated to all members of patient's care team **QM**

Quality Measures

- HEDIS® Measures include(63):
  - Medication reconciliation is completed.
  - Transition of care needs are assessed and addressed.
  - Psychosocial status (eg, depression screening) is assessed and addressed.
  - Fall risk is assessed and addressed.
  - Tobacco use is assessed and addressed.
  - Immunization status is assessed and addressed.
  - Readmission risk is assessed and addressed.
  - Social needs screening and intervention is completed.
- Inpatient Rehabilitation Facility Compare Quality Measures include(220):

- Pressure injury risk is assessed and addressed.
- ADL status is assessed for improvement.
- Fall risk is assessed and addressed.
- Transfer of health information to provider and patient is completed.
- Healthcare-associated infection risk is reduced
- Medication reconciliation is completed.
- Discharge to the community is completed.
- Readmission risk is assessed and addressed.

- Inpatient Rehabilitation Facility Quality Reporting Program measures include(220):
  - Pressure injury risk is assessed and addressed.
  - ADL status is assessed for improvement.
  - Fall risk is assessed and addressed.
  - Transfer of health information to provider and patient is completed.
  - Readmission risk is assessed and addressed.
  - Medication reconciliation is completed.
  - Immunization status is assessed and addressed.
  - Discharge to the community is completed.

Evidence Summary

Criteria

The evidence for the clinical indications found in this guideline includes 23 published peer reviewed articles, 1 specialty society or other evidence-based guideline, 1 Cochrane systematic review, and 25 book sections.

A retrospective cohort study of 5423 patients discharged from an acute hospital setting to an inpatient rehabilitation facility (IRF) found that delayed discharge to the IRF because of IRF capacity strain (ie, bed unavailability, understaffing) was associated with prolonged IRF lengths of stay. This study shows that reducing capacity strain in the IRF setting could reduce discharge delays from acute care and improve rehabilitation efficiency.(4) **(EG 2)** A retrospective review of over 1.9 million inpatient rehabilitation patients discharged between January 2016 and December 2019 showed that 70% of patients had at least one ICD-10 pain diagnosis; pain diagnosis was common among all impairment groups, affecting half of patients in each group, with the highest prevalence in the arthritis and pain syndromes impairment group.(5) **(EG 2)**

Multiple sclerosis: A small prospective blinded trial on multiple sclerosis patients receiving inpatient rehabilitation facility (IRF) rehabilitation vs outpatient clinic rehabilitation found that walking improved with IRF rehabilitation and patients had access to a larger multidisciplinary team to address needs.(6) **(EG 2)** A systematic review of 15 studies including 10,396 patients with multiple sclerosis found that regular specialist evaluation and follow-up to assess patient needs for appropriate rehabilitation interventions may be of benefit. Structured, multidisciplinary rehabilitation programs and physical therapy (exercise or physical activities) can improve quality-of-life and functional outcomes, including mobility, muscle strength, and aerobic capacity.(7) **(EG 1)** A retrospective chart review of 22 newly diagnosed functional neurologic disorder patients with persistent motor symptoms who were admitted to an IRF between September 2019 and May 2022 found that a relatively short IRF stay was associated with statistically significant clinical gains in self-care, transfers, ambulation, and balance. More than 95% of patients were discharged to home.(8) **(EG 2)** A single institution retrospective study of 137 patients who were diagnosed with disorders of consciousness after severe brain injury found almost all patients admitted at the acute stage achieved emergence from a minimally conscious state (90%) and decannulation (94%), 70% achieved an oral diet, and approximately 60% required moderate or less assistance in bed-to-chair transfer, communication, and self-care using the upper limbs at time of discharge.(9) **(EG 2)** An observational study of 52 multiple sclerosis patients evaluated at home after 3 weeks of inpatient rehabilitation showed significant improvements in self-

reported mobility, self-rated health, walking capacity, and mobility measures such as the 10-meter walk test, 2-minute walk test, and Timed Up and Go test for both mildly and severely disabled patients.(10) **(EG 2)**

Parkinson disease: A randomized controlled trial with 70 patients found that a 2-month multidisciplinary rehabilitation program with task-oriented exercises, cognitive-behavioral training, and occupational therapy, as compared with standard physiotherapy, has a significant salutary effect upon key outcomes, including motor impairment, balance, activities of daily living, and quality of life. Incremental effectiveness has continued for at least 1 year after the intervention.(11) **(EG 2)** A set of national guidelines for Parkinson disease suggests the inclusion of neuropsychiatric symptom management.(12) **(EG 2)**

Amyotrophic lateral sclerosis (ALS): A review article endorses the benefits of a multidisciplinary team (ideally with a neurologist, physiatrist, physical and occupational therapists, pulmonologist and respiratory therapist, gastroenterologist, dietitian and nutritionist, neuropsychologist, speech-language pathologist, nurse, and social worker) as the approach to therapy.(13) **(EG 2)**

Length of Stay

A retrospective case series of 147 neurologic rehabilitation patients at a single center found that median length of stay was 71 days; for those patients with acquired brain injury as compared with spinal cord injury length of stay averaged 35 days longer. Length of stay at admission was predicted by diagnostic category, rehabilitation complexity, dependency, and Barthel Index, with dependency score at admission, reflected also as nursing need, the most significant predictor. Age and gender had little effect upon predicting length of stay in such cases.(80) **(EG 2)** For working-age adults receiving inpatient rehabilitation for complex neurologic issues, a prospective multicenter cohort analysis of 5739 such patients (73% with acquired brain injury, 9% with spinal cord injury, 5% with peripheral neurologic conditions, 13% with progressive conditions) found that mean length of stay was 90 days, and all groups showed significant dependency reduction during this time. Those in the highest dependency group achieved greatest reduction in weekly care costs despite longer length of stay.(81) **(EG 2)** A retrospective cohort study of 139 pediatric cerebral palsy (CP) patients admitted to an inpatient rehabilitation unit following a surgical procedure (selective dorsal rhizotomy (SDR), single-event multilevel orthopedic surgery (SEMLS), or intrathecal baclofen (ITB) pump implantation) related to their CP diagnosis found that those in the SDR group had the longest average inpatient rehabilitation length of stay (26.77 days).(28) **(EG 2)**

Treatment

A retrospective study of 479 Medicare patients who received rehabilitation in a nursing home or inpatient rehabilitation facility (IRF) setting found that 1 in 3 patients reported no functional improvement during rehabilitation. Factors associated with greater odds of reporting no improvement included high school education or less, impaired instrumental activities of daily living, less than 1 month total duration of rehabilitation, and no outpatient rehabilitation services.(17) **(EG 2)** A retrospective review of 343,193 Medicare patients discharged from acute inpatient care to an IRF found that those who received vertically integrated care in a hospital-based IRF had shorter inpatient and IRF lengths of stay with maintained or improved health outcomes, fewer readmissions, and were more likely to be discharged to home with home health services when compared with patients who received care in a freestanding IRF (ie, IRF with hospitals within the same health system but not hospital-based).(18) **(EG 2)** A systematic review of 24 articles including adult patients in post-acute care (eg, IRFs, long-term care hospitals, skilled nursing facilities, or home health settings) found that occupational therapy interventions may reduce or manage preventable adverse events. Strong strength of evidence was found to support an exercise program to reduce risk of falls in an IRF. Moderate strength of evidence was found to support facility-wide pressure injury reduction programs to reduce pressure injuries; dysphagia management through multidisciplinary care and strengthening exercises for swallowing; and a multidisciplinary, multicomponent falls program.(19) **(EG 1)** A retrospective analysis of 5,033,820 Medicare patients discharged from acute care to post-acute care found that those discharged to an IRF were least likely to demonstrate cognitive impairment, use a bowel appliance, or be on a therapeutic diet, and had the shortest average length of stay when compared with other post-acute settings.(20) **(EG 2)** A retrospective cohort study of 145,664 patients age 65 or older with **Guillain-Barre syndrome, Multiple Sclerosis, Parkinson disease, or stroke** admitted to an IRF found improvement in functional independence (ie, self-care, mobility, cognition) based on the FIM® scores, in all diagnostic groups from admission to discharge. The largest adjusted percent improvements were observed in the mobility domain and the smallest in the cognition domain for all groups. Percent improvement in mobility ranged from 84.9% (multiple sclerosis) to 144.0% (Guillain-Barre syndrome), self-care from 49.5% (multiple sclerosis) to 84.1% (Guillain-Barre syndrome), and cognition from 34.0% (Parkinson disease) to 51.7% (Guillain-Barre syndrome). Patients with Guillain-Barre syndrome demonstrated the greatest percent improvement across all three domains.(21) **(EG 2)** A retrospective cohort study of 159

adults with hypoxic-ischemic brain injury found that potential determinants of cognitive functional gains were shorter acute care lengths of stay, longer inpatient rehabilitation and length of stay, and proceeding directly to inpatient rehabilitation from acute care.(22) **(EG 2)** A cross sectional study of 586 adults with severe acquired brain injury found that the most frequent comorbidities requiring elevated care assistance included cardiorespiratory monitoring, pressure injuries, and infections. Conditions that limited access to rehabilitation sessions included severe neurologic and clinical conditions, acute organ failure, cardiorespiratory instability, and paroxysmal sympathetic hyperactivity.(23) **(EG 2)** A retrospective cohort study of 270 medically complex inpatient rehabilitation patients reported that patients with ICU-acquired weakness (ICUAW) had significantly greater Functional Independence Measure (FIM®) motor gain than medically complex patients without ICUAW and were 81% more likely to be discharged to home vs to a skilled nursing facility.(24) **(EG 2)** An analysis of a randomized controlled trial suggested that high-intensity interval training (HIIT) can potentially impact the markers of systemic inflammation compared with moderate continuous training, and HIIT may improve symptoms and positively influence disease progression in persons with multiple sclerosis.(25) **(EG 2)** A retrospective study of 3212 patients who were discharged from an IRF found that increased therapy hours were associated with increased functional gains among all types of patients.(26) **(EG 2)** A retrospective observational study performed at a 178-bed inpatient rehabilitation hospital reported that of the 1008 patients who received a psychiatric consultation during their inpatient rehabilitation hospital stay, the most common conditions associated with a psychiatric consult were amputations (38%), burns (35%), neurologic disorder (28%), deconditioning (14%), and musculoskeletal injury (7%). Although 20% of patients did not meet criteria for psychiatric diagnosis, the most common diagnoses included mood disorder, adjustment disorder, neurocognitive disorder, and delirium.(27) **(EG 2)** A retrospective cohort study of 139 pediatric cerebral palsy (CP) patients admitted to an inpatient rehabilitation unit following a surgical procedure (selective dorsal rhizotomy (SDR), single-event multilevel orthopedic surgery (SEMLS), or intrathecal baclofen (ITB) pump implantation) related to their CP diagnosis found that those with higher WeeFIM® change scores tended to have spastic diplegia, to have undergone SDR, have Gross Motor Function Classification System (GMFCS) level II, have longer length of stay, and have higher admission scores.(28) **(EG 2)**

Studies suggest that care models incorporating close to 7-day-per-week care, as compared with 5-day-per-week care, may have positive effects upon patient outcomes, such as functional independence measure scores.(31) **(EG 2)** A claims-based study of 1.4 million Medicare beneficiaries discharged from an acute care hospital to a post-acute care setting, including an inpatient rehabilitation facility (IRF), a skilled nursing facility (SNF), or home care (HC), found that more hours of occupational therapy and physical therapy services were associated with greater functional improvements, and fewer hours of occupational therapy and physical therapy services were associated with a higher risk for 30-day hospital readmission across all post-acute care settings.(32) **(EG 2)** A retrospective study of 3212 patients who were discharged from an IRF found that increased therapy hours were associated with increased functional gains among all types of patients.(26) **(EG 2)**

Care Coordination

An observational review of 567,850 inpatient rehabilitation facility (IRF) Medicare inpatient stays in 1166 facilities during 2013 to 2014 found that adjusted hospital readmission rate 30 days post-IRF discharge was in the range of 12.4% to 13.1%, but almost 75% of facilities demonstrated readmission rates that were significantly different than this average. The mean number of days to readmission was 13.0, which varied significantly by rehabilitation diagnosis.(186) **(EG 2)** A retrospective cohort study of a Medicare claims database involving 371,846 patients discharged from inpatient rehabilitation from 2013 to 2014 found that functional independence at discharge was associated with lower rates of potentially preventable hospital readmissions. Readmission rates for highest vs lowest quartiles within each functional domain were 3.4% vs 6.9% for self-care, 3.3% vs 7.2% for mobility, and 3.5% vs 6.2% for cognition; 44.1% of readmissions were for infection-related conditions, 31.2% were for inadequate management of chronic conditions, and 24.7% were for inadequate management of other unplanned events.(187) **(EG 2)** A retrospective cohort analysis of 539 geriatric patients discharged from acute care to geriatric rehabilitation found that predictors of acute readmission include severe infection, fracture secondary to falls, intra-abdominal complications, cardiac complications, and acute neurologic events.(188) **(EG 2)** An observational cohort study of 682 geriatric patients in an IRF found that risk factors for 30-day and 90-day readmissions included a high fear of falling and higher Charlson Comorbidity Index and Cumulative Illness Rating Scale (CIRS) scores.(62) **(EG 2)** A retrospective analysis of 1,102,785 patient discharges from 944 IRFs found that patient factors associated with 30-day readmissions to acute care included older age, male sex, White race, married, Medicare insured, longer duration of impairment, lower admission FIM® cognitive and motor scores, more comorbidities, dysphagia, pneumonia, and weekend admission to the IRF.(61) **(EG 2)** A retrospective analysis of 3294 patients age 55 years or older discharged from inpatient acute care to either home without home healthcare, home with home healthcare, or an IRF found that most readmissions and emergency department/observation visits within 24 hours came from IRFs. The study also found that patient characteristics associated with readmission from an IRF included younger age, less chronic illness burden, and greater and more recent functional decline.

(189) **(EG 2)** A retrospective study of 75 patients discharged from an acute IRF between 2013 to 2018 who experienced a potentially preventable readmission (PPR) found that individuals were more likely to be readmitted with a PPR if they had a greater number of comorbidities, were admitted with a spinal cord injury, or had lower admission or discharge FIM® motor scores. The most common PPR diagnoses were sepsis, renal failure, respiratory problems, and urinary tract infection.(190) **(EG 2)** An evidence-based improvement study of 79 patients discharged from a 28-bed IRF showed implementing the teach-back intervention from the Agency for Healthcare Research and Quality (AHRQ) Health Literacy Universal Precautions Toolkit into the discharge process resulted in a mean 45% fewer 30-day readmissions.(191) **(EG 2)**

A longitudinal observational study of 43 adult inpatient rehabilitation facility (IRF) patients who were not safe to return home at discharge and required a skilled rehabilitation facility placement found that 58.2% of patients returned to baseline independence, and 63.4% of patients who lived at home prior to acute hospitalization returned home.(192) **(EG 2)** A retrospective analysis of 1954 IRF patients admitted with Guillain-Barre syndrome found that independence at the end of rehabilitation differed significantly between FIM® domains: more patients achieved independence in communication (87.5%) and social cognition (74.8%), while fewer achieved independence in self-care (35.9%), transfers (34.2%), and locomotion domains (24.7%).(193) **(EG 2)** A retrospective observational cohort study of 1304 Guillain-Barre syndrome patients admitted to inpatient rehabilitation facilities found total FIM® scores improved in all groups. Most patients (82%) were discharged to home/community, with the ability to transfer bed/chair/wheelchair being the most important predictive factor associated with discharge destination. FIM® gains were highest among those discharged to the community with an average score of 43.2 compared with a skilled nursing facility FIM® gain of 27.2 and an acute care FIM® gain of 16.5.(194) **(EG 2)**

Rationale

Inpatient rehabilitation facilities are designed to provide intensive rehabilitation therapy in a resource intensive inpatient hospital environment. Use of this MCG care guideline helps in the decision to appropriately admit a patient to an acute inpatient rehabilitation facility and assess progress through an interdisciplinary plan of care that incorporates interventions for skilled nursing (eg, wound care, pain management, infusion medication) and rehabilitation therapy (eg, physical, occupational, speech-language) in alignment with CMS requirements.

Use of these evidence-based clinical criteria benefits patients by assisting in the identification of patients who, due to the complexity of their nursing, medical management, and rehabilitation needs, require and can reasonably be expected to benefit from an inpatient stay and an interdisciplinary team approach to the delivery of rehabilitation care. This evidence-based guidance ensures that Medicare and Medicare Advantage patients receive full access to Medicare benefits without risk of delay or decreased access. Additional evidence-based guidance benefits patients by outlining complicated factors (eg, pain exacerbations, infection, comorbid disease exacerbation) that could extend the need for a rehabilitation facility stay. Criteria for transitioning a patient to the next appropriate level of care (eg, acute care, skilled nursing facility, home care) are also provided to assist providers and patients in identifying next steps for the patient's care. This support can increase consistency in treatment thresholds, leading to less variation in care and promoting equitable treatment among patients.

Related CMS Coverage Guidance

This guideline supplements but does not replace, modify, or supersede existing Medicare regulations or applicable National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs).

Code of Federal Regulations (CFR): 42 CFR 410.38(219); 42 CFR 412.29(3); 42 CFR 412.606(58); 42 CFR 412.610(59); 42 CFR Pt. 412.622(1)

Internet-Only Manual (IOM) Citations: CMS IOM Publication 100-02, Medicare Benefit Policy Manual, Chapter 1 - Inpatient Hospital Services Covered Under Part A(2); CMS IOM Publication 100-08, Medicare Program Integrity Manual, Chapter 6 - Medical Review of Inpatient Hospital Claims for Part A(221)

Medicare Coverage Determinations: Medicare Coverage Database(222)

Other CMS Guidance: Centers for Medicare and Medicaid Services, "Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) and IRF-PAI Manual" Version 4.2(57)

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Footnotes

[A] **National guidelines:** The Centers for Medicare and Medicaid Services (CMS) requires a preadmission screening to be conducted within 48 hours preceding the inpatient rehabilitation admission and is to be completed by a licensed or certified clinician or physician either in person or by telephone through review of the referring hospital medical records.(1) [A in Context Link 1]

[B] **National guidelines:** The Centers for Medicare and Medicaid Services (CMS) required elements of the preadmission screening include: level of function prior to the event, condition that caused the need for rehabilitation, expected level of improvement and expected length of time to achieve that level of improvement, risk for clinical complications, combinations of treatments needed (PT, OT, SLP, or orthosis), and anticipated discharge destination.(1) [B in Context Link 1]

[C] **National guidelines:** The Centers for Medicare and Medicaid Services (CMS) defines reasonable and necessary skilled care as a service that is "so inherently complex that it can only be safely and effectively performed by, or under the supervision of, professional or technical personnel" based on the documented

assessment of the patient's individual care needs. In some cases, a service that would originally be considered unskilled may be considered skilled if the patient's underlying conditions or complications require the involvement of licensed personnel to ensure that essential nonskilled care is achieving its purpose.(14)(15) [C in Context Link 1]

[D] **National guidelines:** According to the Centers for Medicare and Medicaid Services (CMS), the requirement for medical supervision means that a licensed physician who is determined by the inpatient rehabilitation facility to have specialized training and experience in inpatient rehabilitation must conduct face-to-face encounters with the patient at least 3 days per week throughout the patient's stay to assess the patient, as well as to modify the course of treatment as needed to maximize the patient's ability to benefit from rehabilitation. After the first week of physician encounters, CMS will allow a non-physician practitioner to independently conduct one of the three required visits.(2) [D in Context Link 1]

[E] **National guidelines:** According to the Centers for Medicare and Medicaid Services (CMS), the interdisciplinary care team must meet weekly throughout the patient's stay and consist of a registered nurse with specialized training or experience in rehabilitation, a social worker or case manager (or both), a licensed or certified therapist from each therapy discipline involved with the patient's care, and be led by a rehabilitation physician.(2) [E in Context Link 1]

[F] **National guidelines:** The Centers for Medicare and Medicaid Services (CMS) uses a data collection system to establish best practice, understand costs, and identify cost-effective systems and procedures. The current data collection system for eligible patients is the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI). IRF-PAI is an assessment tool used to identify patient problems, strengths, and preferences, and to create an individualized care plan.(57) [F in Context Link 1]

[G] **National guidelines:** Starting October 1, 2024, the Centers for Medicare and Medicaid Services (CMS) requires inpatient rehabilitation facilities to use the Inpatient Rehabilitation Facility Patient Assessment Instrument (IRF-PAI) to assess all inpatients, regardless of payer. The admission IRF-PAI should cover calendar days 1 through 3 of the patient's current admission; the patient assessment schedule is further detailed in the electronic Code of Federal Regulations part 412.610.(58)(59) [G in Context Link 1]

[H] **National guidelines:** The Centers for Medicare and Medicaid Services (CMS) requires that an individualized overall plan of care for the patient is developed by a rehabilitation physician with input from the interdisciplinary team within 4 days of the patient's admission.(1) [H in Context Link 1]

[I] **National guidelines:** The Centers for Medicare and Medicaid Services (CMS) states that therapy treatments should begin within 36 hours of admission.(1)(2) [I in Context Link 1]

[J] **National guidelines:** The Centers for Medicare and Medicaid Services (CMS) recommends that if an unexpected clinical event occurs that limits a patient's ability to participate in an intensive therapy program for a brief period, not to exceed 3 days, the specific reasons for the break should be documented in the patient's medical record.(2) [J in Context Link 1, 2]

[K] Pain assessment should include how pain affects patient's physical and psychosocial function and progress toward treatment goals.(94) [K in Context Link 1]

[L] The patient's agreed-upon written treatment plan should include measurable and realistic functional or quality-of-life goals, pain-management education, treatment options, and safe use of opioid and nonopioid medications as prescribed.(94) [L in Context Link 1]

[M] **National guidelines:** The Centers for Disease Control and Prevention (CDC) recommends nonpharmacologic and nonopioid therapy before opioids for management of chronic pain (not due to malignancy). Considerations for opioids should include pain-management goal setting and determining if benefits outweigh risks. When opioids are prescribed, they should be provided in conjunction with nonpharmacologic pain-management interventions and planned monitoring for misuse or use escalation, including naloxone education.(97) [M in Context Link 1]

[N] Additional instrumental assessment may be requested to evaluate swallowing physiology and assess safety and effectiveness of diet, strategies, and maneuvers prior to and during a course of therapy. Instrumental assessments may include the videofluoroscopic swallow study (also known as the modified barium swallow study) and the fiberoptic endoscopic evaluation of swallowing (FEES).(160)(173)(174) [N in Context Link 1]

[O] Voice therapy, exercise, or practice activities should not be initiated until the larynx has been visualized by an otolaryngologist to identify pathology and assess the function and structure of the vocal mechanism.(161)(181) [O in Context Link 1]

Definitions

Custodial care

- Custodial care is personal unskilled care to support the patient's care of activities of daily living (ADL), such as bathing, dressing, and eating.(1)

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FIM Score

- The Functional Independence Measure (FIM®) is an instrument that classifies a patient's ability to carry out activities and the need for assistance from a person or device. It is a 7-level scale measurement of gradations in behavior (from dependence to independence) that can be used to monitor patient progress throughout rehabilitation and help with care plan development and defining discharge needs.(1)

References

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Goals for measurable improvement

- Goals for measurable improvement include identification of **ALL** of the following(1)(2):
  - Nature and degree of improvement
  - Time expected for achievement
  - Functional improvement anticipated to be practical, ongoing, and sustainable

References

1. Centers for Medicare and Medicaid Services. Medicare Benefit Policy Manual. Chapter 1 - Inpatient Hospital Services Covered Under Part A Rev. 10892 [Internet] Centers for Medicare and Medicaid Services. 2021 Aug Accessed at: https://www.cms.gov/manuals/. [accessed 2025 Sep 09]
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Intensive rehabilitation therapy program

- Intensive rehabilitation therapy program that includes **1 or more** of the following[A](1)(2):
  - Therapy at least 3 hours per day for 5 days per week
  - Therapy at least 15 hours per week (in a 7 consecutive calendar day period starting from the date of admission)

- Other intensive therapy to improve functional capacity at patient's maximum participation level without compromising safety or exceeding ability or tolerance(3)

References

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Footnotes

A. **National guidelines:** The Centers for Medicare and Medicaid Services (CMS) Medicare Benefit Policy Manual states that admissions that are intended to assess if a patient would benefit and tolerate treatment in an inpatient rehabilitation facility (IRF) are no longer considered reasonable and necessary.(1)

Interdisciplinary team care

- Interdisciplinary care team meetings held weekly and discipline examples include(1)(2)(3)(4):
  - A rehabilitation physician designated by the Inpatient Rehabilitation Facility to have specialized training and experience in inpatient rehabilitation services
  - A registered nurse with specialized training or experience in rehabilitation
  - A social worker or case manager (or both)
  - A licensed or certified therapist from each discipline involved in evaluating and treating the patient

References

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Occupational therapy (OT) progression

- OT progression includes **ALL** of the following(1)(2):
  - Ongoing evaluation of treatment plan with measurable short-term and long-term goals
  - Documentation of effectiveness and efficiency toward achieving established goals
  - Patient demonstrates resolving of barriers to transition of care and **1 or more** of the following:
    - Objective measurements document progress toward goals in reasonable and predictable time frame based on treatment plan.[A](4)

- Minimal progress due to unexpected clinical event, but progress expected to resume toward goals within 3 days as condition improves(5)

References

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Footnotes

A. Improvements may be measured by accuracy (percentage or number of correct trials), increased number of repetitions, decreased assistance level (maximum, moderate, or minimal assistance), decreased pain level, increased ROM/strength, increased balance scores, decreased level of cues or prompts required (in conjunction with level of assistance), or improvement in standardized functional outcome measures (eg, Continuity Assessment Record and Evaluation (CARE), WeeFIM®, Tinetti, Berg Balance Scale).(3)(4) Generally, it is expected that measured improvements should be demonstrable in targeted areas over a 1-week to 2-week period of skilled therapy. The speed of recovery is variable and may be linked to intensity of treatment, patient condition, age, comorbidities, and other factors.

Physical therapy (PT) progression

- PT progression includes **ALL** of the following(1)(2)(3)(4):
  - Ongoing evaluation of treatment plan with measurable short-term and long-term goals
  - Documentation of effectiveness and efficiency toward achieving established goals
  - Patient demonstrates resolving of barriers to transition of care and **1 or more** of the following:
    - Objective measurements document progress toward goals in reasonable and predictable time frame based on treatment plan.[A]
    - Minimal progress due to unexpected clinical event, but progress expected to resume toward goals within 3 days as condition improves

References

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Footnotes

A. Improvements may be measured by accuracy (percentage or number of correct trials), increased number of repetitions, decreased assistance level (maximum, moderate, or minimal assistance), decreased pain level, increased ROM/strength, increased balance scores, decreased level of cues or prompts required (in conjunction with level of assistance), or improvement in standardized functional outcome measures (eg, Continuity Assessment Record and Evaluation (CARE), WeeFIM®, Tinetti, Berg Balance Scale). Generally, it is expected that measured improvements should be demonstrable in targeted areas over a 1-week to 2-week period of skilled therapy. The speed of recovery is variable and may be linked to intensity of treatment, patient condition, age, comorbidities, and other factors.(4)(5)

Safe to go home

- Patient safe to go home if **ALL** of the following exist(1)(2)(3):
  - Medical condition manageable at home
  - Functional status manageable at home
  - Mental status stable for patient's condition
  - Medication availability confirmed and reconciliation complete
  - Patient/caregiver education complete and written discharge instructions provided
  - Caregiver and community resources identified (as needed)
  - Community resources identified and referrals made, as needed
  - Home care arranged, if indicated
  - Necessary medical equipment delivery arranged or available in home, if indicated
  - Necessary medical supplies ordered, or patient/caregiver can obtain, if indicated

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Skilled care

- Skilled care may be direct (eg, in-person assessment and administration of treatments) or indirect (eg, coordinating care between providers, supervising care aides); examples include(1)(2)(3)(4):
  - Performed or supervised by professional or technical personnel
  - Exceed scope of Custodial care
  - Service is considered skilled as indicated by either of the following:
    - Service that is "so inherently complex that it can only be safely and effectively performed by, or under the supervision of, professional or technical personnel" based on the documented assessment of the patient's individual care needs.
    - Service that would originally be considered unskilled may be considered skilled if the patient's underlying conditions or complications require the involvement of licensed personnel to ensure that essential nonskilled care is achieving its purpose.

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Speech-language pathology (SLP) progression

- SLP progression includes **ALL** of the following(1)(2)(3)(4)(5):
  - Ongoing evaluation of treatment plan with measurable short-term and long-term goals
  - Documentation of effectiveness and efficiency toward achieving established goals
  - Patient demonstrates resolving of barriers to transition of care and **1 or more** of the following:
    - Objective measurements document progress toward goals in reasonable and predictable time frame based on treatment plan.[A](6)
    - Minimal progress due to unexpected clinical event, but progress expected to resume toward goals within 3 days as condition improves

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Footnotes

A. Improvements may be measured by accuracy (percentage or number of correct trials), increased number of repetitions, decreased assistance level (maximum, moderate, or minimal assistance), decreased pain level, decreased level of cues or prompts required (in conjunction with level of assistance), or improvement in standardized functional outcome measures (eg, Continuity Assessment Record and Evaluation (CARE), WeeFIM®, National Outcomes Measurement System

(NOMS)). Generally, it is expected that measured improvements should be demonstrable in targeted areas over a 1-week to 2-week period of skilled therapy. The speed of recovery is variable and may be linked to intensity of treatment, patient condition, age, comorbidities, and other factors.(2)(6)(7)

Transition of care planning completed

- Transition of care planning completed; including **ALL** of the following(1)(2):
  - Transition plan communicated to all members of patient's healthcare team
  - Summary of inpatient rehabilitation facility admission, current list of medications, and discharge plan communicated to primary care provider at next level of care
  - Medication reconciliation complete
  - Education on condition management and complications to report provided to patient or caregiver
  - Follow-up appointments scheduled
  - Referrals to continue rehabilitation goals (eg, outpatient or home therapy) arranged, if needed
  - Services (eg, equipment, environment modifications, transportation) required for transition to next level of care arranged, if needed
  - Psychosocial issues addressed, or plan for management at next level of care arranged, if needed

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Codes

ICD-10 Diagnosis: A01.01, A02.21, A06.6, A17.0, A17.1, A17.81, A17.82, A17.83, A20.3, A22.8, A27.81, A32.11, A32.12, A39.0, A39.81, A42.81, A50.40, A50.41, A50.42, A50.43, A51.41, A52.11, A52.13, A52.14, A52.16, A52.17, A52.19, A54.81, A69.21, A80.0, A80.1, A80.2, A80.30, A80.39, A83.0, A83.1, A83.2, A83.3, A83.4, A83.5, A83.6, A83.8, A84.0, A84.1, A84.81, A84.89, A85.0, A85.1, A85.2, A85.8, A86, A87.0, A87.1, A87.2, A87.8, A87.9, A88.0, A88.8, A89, A92.0, A92.1, A92.2, A92.31, A92.4, A92.8, A93.0, B00.3, B00.4, B01.0, B01.11, B02.1, B05.0, B05.1, B06.01, B06.02, B10.01, B10.09, B26.1, B26.2, B27.02, B27.12, B27.82, B27.92, B33.1, B37.5, B38.4, B45.1, B58.2, B91, B94.1, B97.33, C70.0, C70.1, C70.9, C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, C71.9, C72.0, C72.1, C79.31, C79.40, C79.49, D32.0, D32.1, D32.9, D33.0, D33.1, D33.2, D33.3, D33.4, D42.0, D42.1, D42.9, D43.0, D43.1, D43.2, D43.4, D49.6, D49.7, E08.42, E09.42, E10.42, E11.42, E13.42, G00.0, G00.1, G00.2, G00.3, G00.8, G00.9, G01, G02, G03.0, G03.1, G03.2, G03.8, G03.9, G04.00, G04.01, G04.02, G04.2, G04.30, G04.31, G04.32, G04.39, G04.81, G04.82, G04.89, G04.90, G04.91, G05.3, G05.4, G06.0, G06.1, G08, G09, G10, G11.0, G11.10, G11.11, G11.19, G11.2, G11.3, G11.4, G11.6, G11.8, G12.1, G12.20, G12.21, G12.22, G12.23, G12.24, G12.25, G12.29, G12.8, G12.9, G13.0, G13.1, G14, G20.A1, G20.A2, G20.B1, G20.B2, G20.C, G21.0, G21.11, G21.19, G21.2, G21.3, G21.4, G21.8, G21.9, G23.0, G23.1, G23.2, G23.3, G23.8, G23.9, G24.01, G24.02, G24.09, G24.1, G24.2, G24.3, G24.4, G24.5, G24.8, G24.9, G25.0, G25.1, G25.2, G25.3, G25.4, G25.5, G25.61, G25.69, G25.70, G25.71, G25.79, G25.81, G25.82, G25.83, G25.89, G25.9, G26, G30.0, G30.1, G30.8, G30.9, G31.1, G31.80, G32.0, G36.0, G36.1, G36.8, G37.0, G37.1, G37.2, G37.3, G37.4, G37.5, G37.81, G37.89, G40.001, G40.009, G40.101, G40.109, G40.201, G40.209, G40.301, G40.309, G40.401, G40.409, G40.42, G40.501, G40.509, G40.801, G40.802, G40.811, G40.812, G40.821, G40.822, G40.833, G40.834, G40.89, G40.901, G40.909, G40.A01, G40.A09, G40.B01, G40.B09, G40.C01, G40.C09, G40.C11, G40.C19, G45.0, G45.1, G45.3, G45.8, G45.9, G46.0, G54.1, G60.0, G60.1, G60.2, G60.3, G60.8, G61.0, G61.1, G61.81, G61.82, G61.89, G62.0, G62.1, G62.2, G62.81, G62.82, G62.89, G62.9, G63, G64, G65.0, G65.1, G65.2, G70.00, G70.01, G70.1, G70.2, G70.89, G71.00, G71.01, G71.02, G71.031, G71.032, G71.033, G71.0340, G71.0341, G71.0342, G71.0349, G71.035, G71.038, G71.039, G71.09, G71.11, G71.12, G71.13, G71.14, G71.20, G71.21, G71.220, G71.228, G71.29, G71.3, G71.8, G72.0, G72.1, G72.2, G72.3, G72.81, G72.89, G73.3, G73.7, G80.0, G80.1, G80.2, G80.3, G80.4, G80.8, G80.9, G81.01, G81.02, G81.03, G81.04, G81.11, G81.12, G81.13, G81.14, G81.91, G81.92, G81.93, G81.94, G83.0, G83.11, G83.12, G83.13, G83.14, G83.4, G83.5, G83.81, G83.82, G83.83, G83.84, G83.89, G90.09, G90.2, G90.3, G90.4, G90.50, G90.511, G90.512, G90.513, G90.519, G90.521, G90.522, G90.523, G90.529, G90.59, G90.9, G90.B, G91.0, G91.1, G91.3, G91.8, G91.9, G92.00, G92.01, G92.02, G92.03, G92.04, G92.05, G92.8, G92.9, G93.0, G93.1, G93.40, G93.41, G93.42, G93.43, G93.44, G93.49, G93.5, G93.6, G93.81, G95.0, G95.11, G95.19, G95.81, G95.89, G97.2, G97.81, G97.82, G99.2, H81.20, H81.21, H81.22, H81.23, H81.4, I65.01, I65.02, I65.03, I65.09, I65.1, I65.21, I65.22, I65.23, I65.29, I65.8, I65.9, I66.01, I66.02, I66.03, I66.09, I66.11, I66.12, I66.13, I66.19, I66.21, I66.22, I66.23, I66.29, I66.3, I66.8, I66.9, I67.4, I67.5, I67.6, I67.7, I67.850, I68.2, M35.06, M35.07, M43.3, M47.011, M47.012, M47.013, M47.014, M47.015, M47.016, M47.019, M47.021, M47.022, M47.029, M47.10, M47.11, M47.12, M47.13, M47.14, M47.15,

M47.16, M50.00, M50.01, M50.03, M50.10, M50.11, M50.13, M51.04, M51.05, M51.06, M51.14, M51.15, M51.17, M54.10, M54.11, M54.12, M54.13, M54.14, M54.15, M54.17, M54.18, Q03.9, Q05.9, R56.00, R56.01, R56.1 [Hide]

DSM-5: G20.C, G21.0, G21.11, G21.19, G24.01, G24.02, G24.09, G25.1, G25.71, G25.79, G25.81

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